Kennedy, Alice

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Sent: Monday, July 24, 2017 3:07 PM
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Cc: Hickman, Selina; Carmichael, Erin
Subject: CQS Public Comment and Draft State Responses
Attachments: VT GC CQS March 24, 2017 Public Posting Final.pdf; CQS Pubic Hearing Comments with draft State Responses July 24, 2017.docx

Hi All,

As you may recall, a formal public hearing for the attached Comprehensive Quality Strategy (CQS)/State Transition Plan (STP) was held on Thursday, April 21, 2017 from 1pm - 2pm at the Waterbury State Office Complex (WSOC). While no individuals from the community attended the hearing – I did receive three pieces of written feedback during the public comment period. I have attached a Word file that contains a summary of the public comments from these documents – along with draft State responses. As you will notice – not all comments have responses.

I am asking that you edit my draft responses – as well as suggest language for those comments w/o responses - by cob this Friday, July 28th. Once this document is complete – I will modify the CQS/STP accordingly – and submit it to CMS for review. Please feel free to contact me with any questions.

Thank you,

Shawn

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VERMONT

MEDICAID COMPREHENSIVE QUALITY STRATEGY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

Produced by
Members of the
AHS Performance Accountability Committee (PAC)
March 24, 2017

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HCBS Transition Plan Preface

Orientation

On October 24, 2016, the Center for Medicare and Medicaid Services (CMS) approved Vermont's request to continue the Global Commitment to Health (GC) 1115 waiver. As per the waiver's Special Terms and Conditions (STCs), Vermont shall expand on the managed care quality strategy requirements at 42 CFR 438.340 and adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This document is known as the Comprehensive Quality Strategy (CQS). Vermont's GC CQS is intended to serve as a blueprint for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it describes specifications for quality assessment and performance improvement activities that the Agency of Human Services (AHS) will implement to ensure the delivery of quality health care. CMS also requires states to submit a State Transition Plan (STP) that documents how they will comply with the new HCBS rules at 42 CFR 441. Rather than developing a separate state transition plan – Vermont has opted to have the CQS demonstrate the state's compliance with the HCBS requirements and should suffice as the Statewide Transition Plan. Thus, the CQS identifies the framework and strategy for achieving and maintaining compliance with the Medicaid Managed Care regulations found at 42 CFR 438 as well as the new federal HCBS requirements at 42 CFR 441 for all applicable Vermont HCBS programs.

While much of the Comprehensive Quality Strategy (CQS) outlines how Vermont plans to assess and improve the quality of care that Medicaid Managed Care beneficiaries receive, the following three sections of the CQS respond specifically to the requirements of a home and community-based settings transition plan:

- HCBS Transition Plan Preface (pp. 3-15)
- The fourth part of Section III: State Standards (pp. 58-62)
- Appendix A-E VT HCBS Program Systemic Assessments and Work Plans (links on pp. 78-82)

Overview

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home and community-based settings (HCBS), with additional guidance and information posted on March 18, 2014. The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving services and supports under 1915(c), 1915(k), and 1915(i) Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting.

Background

In all Vermont programs, consumers have equal access to an array of traditional state plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing and other rehabilitative therapies and service options. The final service package is based on consumer choice, individualized planning, medical necessity (including level of care determinations) and medical

appropriateness; thus, individual plans may include institutional (Nursing Facility and PNMI), home-based and other rehabilitative based services as part of their person-centered planning process. Regardless of the setting beneficiaries choose, Vermont's values are in alignment with the Federal HCBS rules and Managed Long Term Services and Support Guidance. Based on considerable stakeholder interest, Vermont is taking this opportunity to assess programs/settings for GC Demonstration populations that are designated by the State as persons with Special Health Care needs under 42 CFR 438. An overview of the programs and their settings can be found below.

Choices For Care Program (CFC)

Persons may become eligible for participation in the Choices for Care (CFC) Long-Term Care program by meeting Medicaid Long-Term Care eligibility rules, 1915(c) institutional eligibility rules, GC Demonstration population rules, and by also meeting clinical criteria for High, Highest, or Moderate Needs services. Persons designated as High or Highest Needs must meet nursing facility level of care, and persons with Moderate Needs are at risk for nursing home level of care. Persons with Moderate Needs are eligible for a limited benefit package to assist them in remaining in their home. Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules and are in the High or Highest Needs Group (i.e., meeting a nursing facility level of care).

In the CFC program consumers have equal access to an array of traditional State Plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing, home–based, and other rehabilitative service options. The final service package is based on consumer choice, individualized planning, medical necessity (including level-of-care determinations), and medical appropriateness; thus, individual plans may include institutional, home-based, and other rehabilitative-based services as part of their person-centered planning process.

Most Choices for Care services are provided to participants in their homes. However, persons may also choose to reside in one of the following out-of-home setting types:

- *Adult Family Care (AFC)* – A 24-hour, home-based, shared living arrangement providing care for no more than two persons unrelated to the provider. Adult Family Care homes must meet DAIL safety and accessibility standards prior to participant placement, with inspections every three years. Each AFC home maintains a contract with a Host Agency responsible for quality oversight and case management services on behalf of the participant. An Adult Family Care Coordinator from the host agency assists the home provider and participants in creating a person-centered care plan and live-in agreement. Home providers do not serve as case managers or guardians for persons in their care.

- *Enhanced Residential Care (ERC)* – Residential Care Homes in Vermont are licensed to provide room, board, and personal care to three or more residents unrelated to the provider. CFC ERC services involve a daily package of services provided to individuals residing in an approved, Vermont Licensed Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). All CFC ERC providers must also be enrolled as Medicaid Assistive Community Care Service (ACCS) providers and receive a Medicaid payment for Assistive Community Care Services (i.e., private non-medical institution), as well as an enhanced residential care payment for services to CFC participants. Prior to participation in the CFC ERC program, providers must request a variance of licensing standards that restrict residential admissions to persons who do not meet

Nursing Facility level of care. In addition to these residential arrangements, CFC participants who are residing in their own homes or in an Adult Family Care setting may also receive Day Health Rehabilitation from a State-Certified Adult Day Service provider. Day Health Rehabilitation is a State Plan service and is defined below.

- Day Health Rehabilitation: Services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services.

Due to the nature of Vermont's Medicaid State Plan, the GC STCs, and Medicaid Managed Care rules, expenditures for the full continuum of service (home based, shared living, enhanced residential, and nursing facility care), commensurate with participant needs and choice, are allowable under Vermont's Section 1115 Demonstration.

Respite Care is a flexible option that is available only to persons who are in home or community settings (i.e. in their own home or in Adult Family Care). Respite may be provided in any setting that the participant chooses. Respite settings may include the persons own home, a Residential Care Home, an Adult Family Care Home, an Adult Day Program or a Nursing Facility.

Companion Care is also an option available only to persons who are in home or community settings (i.e. in their own home or in Adult Family Care). Companion care is provided in the home setting.

In addition to Choices for Care specific program policies, the settings policies and regulations that govern Adult Day, Adult Family Care, Residential Care Home and Nursing Facilities also extend to the Respite services that may be provided in those settings.

Developmental Disabilities Services (DDS)

DDS supports are meant to maximize independence while protecting the health, wellness, and safety of consumers who are considered part of a vulnerable/special health needs population under the Global Commitment to Health Medicaid Managed Care model. Services to children under 21 are expected to focus on developmental growth and assistance with skill building whenever possible. DDS programs for persons over the age of 21 are meant to provide long-term services and supports, and enrollment is frequently expected to be life-long in nature.

The DDS program includes services and supports provided by private non-profit developmental disabilities services providers throughout the state to assist individuals who have a developmental disability to live and work in their communities. Services include service coordination, community supports, employment supports, respite, clinical services, crisis services, home supports, and transportation. The State's only public institution providing developmental disability services, Brandon Training School, was closed in 1993. The last sheltered workshop was closed in 2002. All program services are provided in the community. Individual support plans and associated services are highly individualized and based on person-centered planning, consumer choice and allowable services as defined in the DDS State System of Care Plan.

Home Supports include services, supports, and supervision provided to individuals in and around their residences up to twenty-four hours a day, seven days a week (24/7). An array of services is provided to individuals, as appropriate, in accordance with an individual planning process that results in an Individual Support Agreement (ISA). The services include the provision of assistance and resources to

improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include support for individuals to acquire and retain life skills and for maintaining health and safety. Support for home modifications required for accessibility for an individual with a physical disability may be included in Home Supports. Home Supports does not include costs for room and board. Below are the types of residential arrangement available in the DDS program.

- *Supervised Living* - These arrangements include regularly scheduled or intermittent hourly supports provided to an individual who lives in his or her home or that of a family member. Supports are provided on a less-than-full-time (not 24/7) schedule.

- *Shared Living* – These arrangements provide individualized support for one or two adults and/or children in the home of a contracted home provider. Home providers typically have 24-hour, seven-day-a-week responsibility for the individuals who live with them. No more than two individuals may live in or receive respite in the same home. All shared living arrangements must meet DDS safety and accessibility standards prior to participant placement. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the participant. Home providers do not serve as case managers or guardians for persons in their care.

- *Staffed Living* These arrangements provide individualized support for one or two adults and/or children in a home setting. Home settings are staffed on a full-time basis by paid providers. No more than two individuals may live in or receive respite in the same setting. All staffed living arrangements must meet DDS safety and accessibility standards prior to participant placement.

- *Group Living* - These arrangements require the setting to be licensed by the Division of Licensing and Protection. For recipients who are under the age of eighteen, the setting must be licensed by DCF as a Residential Child Care Facility or Foster Home. Group Living arrangements include supports provided in a home setting for three to six people that are staffed full time by paid providers. The Vermont State System of Care Plan does not allow funds to be used to increase the availability of settings that provide residential supports to more than four persons over the age of 18 without approval of the Commissioner; no setting may serve more than six adults. Currently, there are no group settings for children that exceed two participants.

- ICF/DD - An Intermediate Care Facility for people with Developmental Disabilities is a highly structured residential setting for up to six people. ICF/DD settings provide needed intensive medical and therapeutic services.

Traumatic Brain Injury (TBI)

This program diverts and/or returns Vermonters, with a moderate to severe traumatic brain injury, from hospitals and other out-of-state facilities to a community-based or less restrictive residential setting. The goals of the program are intended to support individuals to achieve their optimum independence at home and help them return to work. Vermont's TBI program contains two components: A recovery oriented and rehabilitative program and a long-term support program. A determining factor for acceptance into the TBI includes a person's potential for rehabilitation and recovery. The primary goal of the program is considered short term in nature. Overtime, it is expected that the services and supports necessary will

decrease culminating with graduation from the program. Persons who reach their maximum potential in the rehabilitation program, that are subsequently identified as needing long term services and supports, are considered for transfer into the Choices for Care program. However, if a person does not meet the criteria necessary to receive their long-term services and supports from the Choices for Care program, TBI program enrollment is not terminated, the person may be assessed for continuation in the TBI long term care program as openings are available. In State Fiscal Year 2015, the TBI program served 82 individuals, of that group, approximately 27 persons were receiving long term services and support through the TBI program. Currently only 3 people receiving long term service and supports are residing in Residential Facilities and those persons are in the process of transitioning to the Choices for Care Program.

The TBI program includes services and supports provided by private non-profit agencies that specialize in TBI recovery and support throughout the state. Providers must be approved by the TBI program and adhere to certain training, service planning and documentation requirements. All program services are provided in the community. Individual support plans and associated services are highly individualized and based on a variety of functional assessments, the person's medical profile and individual consumer choice about where to receive services.

In most cases, rehabilitative services are provided in the persons own home or family home, however, when this is not possible residential care and supervised living options are available to consumers. All residential settings (3 or more persons) are licensed as Level III or Level IV Residential Care Homes. For persons who receive 1:1 support in supervised living arrangements, the home provider must be working with a host Agency authorized to provide TBI services.

TBI recovery plans may include twenty-four hours a day, seven days a week (24/7) support. An array of services is provided to individuals, as appropriate, in accordance with an individual planning process that results in a Plan of Care. The plan of care is reviewed and approved by TBI Program staff prior to implementation. Services include support for individuals to recover and retain life skills and for maintaining independence, community living, health and safety. For individuals who are not able to return home following their brain injury, residential supports may include the following types of community living and residential arrangements are available.

- *Supervised Living* – These arrangements provide support for persons who require less than 24/7 care and/or supervision during their recovery. Support may be in the persons own home, or in a shared or staffed living situation.

- *Shared Living* – These arrangements provide support to individuals in the home of a contracted home provider. Home providers typically have 24-hour, seven-day-a-week responsibility for the individuals who live with them. Home providers are expected to work closely with the care manager, life skills aid and rehabilitation team to assure care is aligned with rehabilitation goals and objectives. All supervised living arrangements must meet TBI safety and accessibility standards prior to participant placement. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the participant. Home providers do not serve as case managers or guardians for persons in their care.

- *Staffed Living* - These arrangements provide individualized support for one or two persons in a home setting. Home settings are staffed on a full-time basis by paid providers. All staffed living arrangements must meet safety and accessibility standards prior to participant placement.

- *Residential Facilities* - These arrangements require the setting to be licensed by the Division of Licensing and Protection as a Level III or IV Residential Care Home and also approved by the TBI program to accept participants needing recovery or long term support.

Community Rehabilitation and Treatment (CRT)

The Department of Mental Health (DMH) and its provider system have a strong dedication to serving persons in their home, community, school, and work settings. The CRT program operates using best practices in psychiatric treatment. Those practices promote rehabilitative and recovery services in the individual's own home. However, when this is not possible, residential recovery options are available to persons experiencing a severe and persistent mental illness. These residential treatment programs are licensed as Therapeutic Community Residences or as Level III Residential Care Homes and may also be enrolled as Assistive Community Care Private Non-Medical Institution (PNMI) providers under the Medicaid State Plan. Housing and Home Supports provide services, supports and supervision to individuals in and around their residences up to 24 hours a day and include:

- *Supervised/Assisted Living* Consists of regularly scheduled or intermittent (hourly) supports provided to an individual who lives in his or her home or that of a family member. These settings are neither provider-owned nor provider-controlled.

- *Group Living* consists of group living arrangements for three or more people, owned and/or staffed full-time by employees of a provider agency. These recovery-oriented arrangements can be short-term or long-term residential arrangements that may or may not include rental subsidies. In the CRT system of care, group living arrangements include all residential programs (long-term residential, transitional residential, or otherwise) that are funded through the CRT program.

- *Intensive Residential Treatment* consists of group arrangements for three or more people, staffed full-time by employees of a provider agency. These arrangements are designed to be recovery oriented and not considered long-term permanent living options.

On a limited basis, the CRT program supports highly individualized Wraparound packages to divert or reduce the need for continued hospitalization; these plans may include placements in shared or staffed settings described below. It is estimated that 30 to 40 persons per year may require this level of support. Enhanced funding is requested and prior-approved on a person-by-person basis:

- *Shared Living Home Providers* are individualized shared-living arrangements for adults, offered within a home provider's home. Home providers are contracted workers and are not considered staff of the host agency in their role as contracted provider.
- *Staffed Living* consists of residential living arrangements for one or two people, staffed full-time by employees of a provider agency.

Enhanced Family Treatment (EFT)

The Department of Mental Health (DMH) and its provider system have a strong dedication to serving children, youth and their family in their home, community and school. Home and community based services are provided agencies designated by DMH to support in home service packages, however there are times when an out-of-home placement is necessary in order to achieve specific skill development and provide more intensive treatment options. When an out-of-home placement is necessary, they are expected to be short term or intermittent in nature. Placements are approved for up to six months to provide intensive treatment and providers are expected to work in conjunction with the child family to address identified. DMH expects that families will be supported to remain together whenever possible. The family is the cornerstone of treatment; they are not only involved in developing the treatment plan, but are active participants in the treatment and evaluation of services. Active family involvement helps to ensure that treatment services are individualized to the family's needs, are culturally sensitive and appropriate, and support a focus on the family's strengths, resources, and natural supports.

The Enhanced Family Treatment program diverts and/or returns children from psychiatric or intensive residential placement. Services are based on best practice in EPSDT and Wraparound care and are designed to support children in living in a family home with an intensive package of treatment services and supports commensurate with clinical assessments. The major difference between the EFT and other treatment plans is the ability to provide out-of-home community-based therapeutic care. These included:

- *Therapeutic Foster/Respite Care or Shared Parenting*– These arrangements provide individualized support for children in the home of a contracted foster home provider. Foster home arrangements may include 24-hour, seven-day-a-week services or a shared parenting arrangement whereby children live part time in the foster home and part time with their family as members learn new skills and positive coping strategies for family living. Home providers are expected to work closely with the case manager, family and treatment team to assure care is aligned with family integration goals and the child's treatment plan objectives. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the child. Home providers do not serve as case managers or guardians for children in their care.

- *Transitional Living* - These arrangements are targeted to children and adolescents transitioning to home from psychiatric or intensive residential treatment and adolescents transitioning to adulthood. These settings are required to be licensed by the Department of Children and Families as a Residential Treatment Facility. Each community setting serves no more than 4 children or youth.

The EFT program includes services and supports provided by private non-profit agencies that specialize in intensive treatment for children who are experiencing severe emotional disturbance and their families. Providers must be approved by DMH program and adhere to certain training, service planning and documentation requirements. All program services are provided in the community. Individual treatment plans and associated services are highly individualized and based on a variety of functional assessments, the child and family's clinical profile, values and cultural preferences and choice about where to receive services.

Comprehensive Quality Strategy Transition Plan Elements

Vermont's Global Commitment to Health Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it describes specifications for quality assessment and performance improvement activities that the Agency of Human Services (AHS) will implement to ensure the delivery of quality health care. In addition, the CQS identifies the framework and strategy for achieving and maintaining compliance with the federal HCBS requirements for Choices for Care HCBS programs as well as all Special Health Need Populations served under the Demonstration. Specifically, the CQS contains the following Transition Plan elements:

a. *Systemic Assessments*: These documents assess the existing Vermont regulations and standards related to HCBS delivery to determine if they meet the federal HCBS final rule requirements. One assessment is included for each special health need population. Items are scored as alignment, partial alignment, silent, or non-compliant. All items that do not receive a score of alignment are subject to remediation or corrective action plans and included on the associated Work Plan. Please see **Appendixes A-E** of this strategy for links to individual program Systemic Assessments.

b. *Work (Remediation) Plans*: These documents expand upon the Systemic Assessment by identifying subsequent action steps including timelines, milestones and monitoring process, for the Vermont regulations and standards that did not receive a score of alignment. The action step must resolve the identified issue and bring the Vermont regulation and/or standard into alignment with the federal HCBS final rule. One work plan is included for each special health need population. Please see **Appendixes A-E** of this strategy for links to individual program Work Plans.

c. A description of the *Public Input Process*. Vermont is committed to ensuring that all element of our statewide Comprehensive Quality Strategy (CQS) are reviewed publicly and that public input is incorporated into the final version of the strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii). Prior to submission of the CQS, the state will:

    - Allow a minimum of a 30-day public comment period on the CQS
    - Consider public comments and modify the CQS accordingly
    - Submit evidence of public comment and our response to comments

The CQS and all related documents can be found here http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy

Approach

Vermont is taking a phased approach to HCBS setting rule implementation. This approach will allow the state to use lessons learned in early phases to be incorporated in later phases and ensures that a solid foundation of quality assurance and improvement is in place that aligns with Vermont's statutes, policies and values related to home and community delivery systems. Table 3 below outlines Vermont's phased approach to implementing the new HCBS rules identified in their waiver STCs.

Table 3: Global Commitment to Health Specialized Program Assessment and Quality Phases

	GC Specialized Program Implementation Phases				
	Choices for Care	Developmental Services	Traumatic Brain Injury	Community Rehabilitation and Treatment	Enhanced Family Treatment (Mental Illness under 22)
Quality Strategy Timeline					
Phase 1: Due 12/31/15	✓				
Phase 2: Due 12/31/16	✓	✓	✓		
Phase 3: Due 12/31/17	✓	✓	✓	✓	✓
Phase 4: Due 12/31/18	✓	✓	✓	✓	✓

The paragraphs that follow identify the major tasks associated with each phase.

Phase 1: CFC Initiation

This phase begins with updating the Global Commitment (GC) Comprehensive Quality Strategy (CQS). The CQS serves as a blueprint or road map for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. The critical elements of the CQS are: performance measures, performance improvement projects, and compliance with federal and state regulations including Medicaid Managed Care, the new HCBS settings rules, and the Special Terms and Conditions of the waiver. During this phase, AHS will establish a framework that sets the stage for the subsequent three phases. Specific milestones in phase one include: conducting a systemic assessment for the Choices for Care program, using the results of the systemic assessment to develop a work plan that identifies remedial action steps, developing an overall remediation strategy, establishing a heightened scrutiny plan and process, drafting a relocation plan and process, proposing a plan for ongoing monitoring, as well as educating stakeholders and consumers re: the process. A link to the CFC **systemic assessments** and **work plans** can be found in Appendix A of this document.

Phase 2: DS, TBI, CRT, and EFT Initiation

This phase broadens the scope of the activities described in phase one to include additional GC Demonstration populations that are designated by the State as persons with Special Health Care needs under 42 CFR 438. During this phase, systemic assessments and work plans (aka remediation plans) are developed for those beneficiaries receiving Developmental Disabilities Services (DS), Traumatic Brain Injury services, Community Rehabilitation Treatment (CRT), and Enhanced Family Treatment (EFT) services. Like the process described above for CFC, the State will determine if there are deficiencies and the best mechanism for remediation and quality improvement. Phase two activities will follow the same process (including stakeholder involvement) and produce documents that contain the same key elements as those generated for the CFC program described in Phase 1 above. Links to the DS, TBI,

CRT, and EFT **systemic assessments** and **work plans** can be found in Appendix B-E of this document. Also during this time, the state will begin to implement remediation activities identified in the CFC work plan that was developed in the previous phase. Timelines for the activities will depend on the nature of the corrective action. Changes in legislative rules or statute may take three to twelve (or more) months depending on the committee agenda and nature of the change requested. Changes involving program policies can typically be instituted in one to three months depending on their complexity and the level of stakeholder review required. During this phase, the state also plans to develop survey instruments and protocols to conduct comprehensive site-specific assessments of all HCBS settings to assess the extent to which HCBS settings comply with, are contradictory to or are silent on the requirements under the new HCBS rules. The assessment tool initially identified is a provider self-assessment survey. Copies of provider surveys can be found here: http://dvha.vermont.gov/global-commitment-to-health/hcbs-surveys

In addition, the state will develop a plan to validate the results of the provider-specific self-assessment. At this time, the state plans to validate the results using a mixed-methods approach – using consumer survey as well as data from related oversight and monitoring activities that use a variety of desk and on-site review methodologies and tools. Copies of the consumer surveys can be found here: http://dvha.vermont.gov/global-commitment-to-health/hcbs-surveys

Finally, during this stage, the state will review and modify (as necessary) their overall remediation strategy, heightened scrutiny plan and process, relocation plan and process, and plan for ongoing monitoring. As with phase 1 above, the state will continue to educate and involve stakeholders and consumers in the process.

Phase 3: Initiation and Provider Self-Assessment and Validation

During this time, the state will continue to implement and finalize remediation activities identified in the CFC work plan and begin to implement remediation activities identified in the DS, TBI, CRT, and EFT work plans. As with CFC, timelines for the activities will depend on the nature of the corrective action. Also during this phase, the state also plans to implement the survey instruments and protocols necessary to conduct a comprehensive site-specific assessment of all HCBS settings (i.e., provider assessments and validation activities). In addition, the state plans to draft remediation strategies and corresponding timelines that will resolve issues that the site-specific settings assessment process and subsequent validation strategies identify. Based on the results, remediation will need to be developed for any services, settings, or policies that are determined to not meet the federal HCBS requirements. Please see separate **remediation strategies** section below for more detail. Finally, during this stage, the state will continue to review and modify as necessary their overall remediation strategy, heightened scrutiny plan and process, relocation plan and process, and plan for ongoing monitoring. As with the above phases, the state will continue to educate and involve stakeholders and consumers in the process.

Phase 4: Maintenance

The purpose of the Maintenance phase is to ensure long-term continuity by establishing all activities identified above as a core element and essential monitoring functions within Vermont's Medicaid managed care-like entity. During this phase, the state will finalize items on all Corrective Action Plans that were generated because of the systemic assessment, site-specific settings assessment, or validation

activities, and also begin routine monitoring of compliance with the requirements of the new rules for providers for whom no Corrective Action Plan is in effect. Starting with year 4, it is expected that the necessary structures and processes will be in place to support ongoing monitoring and oversight activities. The monitoring of the compliance the new HCBS rules will be an ongoing process that will be incorporated into existing quality assessment and performance improvement processes. More detail can be found in the **ongoing monitoring** section below. The CQS will be updated to capture the outcomes of this work. Full compliance for all GC populations included in this phased approach is expected to take place by March 17. 2019.

Site Specific Settings Assessment

The state plans to develop survey instruments and protocols as well as complete comprehensive site-specific assessments of all HCBS settings to assess the extent to which HCBS settings comply with, are contradictory to or are silent on the requirements under the new HCBS rules. Providers will complete a self-assessment survey instrument to assess their level of compliance with the new rules. To increase the response rate, a process will be created to follow-up with providers failing to meet requested response timeframes. Based on the results of the survey, an authorized representative of each provider will attest in writing whether they believe that their organization's rules and policies are either fully compliant with the new rules or that remediation is necessary. Providers that indicate that remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider self-assessment

Remediation Strategies

The state plans to draft remediation strategies and corresponding timelines that will resolve issues that the systemic assessment, site-specific settings assessment process, and subsequent validation strategies identify by the end of the HCBS rule transition period (March 17, 2019). Based on the results, remediation will need to be developed for any services, settings, or policies that are determined to not meet the federal HCBS requirements. Providers for which remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the assessment activity. Any Corrective Action Plans and other remediation strategies must be fully implemented by March 17, 2019 so that the entire service delivery system will be compliant with the new rules.

Following the detailed systemic review of each program, the State will determine if there are deficiencies and the best mechanism for remediation and quality improvement. Final timelines will depend on the nature of the corrective action. Changes in legislative rules or statute may take three to twelve (or more) months depending on the committee agenda and nature of the change requested. Changes involving program policies can typically be instituted in one to three months depending on their complexity and the level of stakeholder review required.

If a provider is found deficient in any area, the State will work with them, through a corrective action process, to improve the quality of care and the setting characteristics to align with State and federal HCBS standards. During this time, participants will have the choice of continuing to receive services from the provider while the provider implements corrective action to bring the setting into compliance or transition to a new provider. Please see separate **relocation plan and process** section below for more detail. For programs that the State identifies as needing heightened scrutiny, an on-site assessment by State staff will be conducted. Please see following **heightened scrutiny plan and process** section for more detail.

Heightened Scrutiny Plan and Process

During the systemic assessment process of any of the phases listed above, the State might identify settings that are presumed to have the qualities of an institution. The State does not anticipate removing beneficiary choice in settings. In these Specialized Programs, the Section 1115 Demonstration provides an equal entitlement to institutional and community based services commensurate with a recipient's clinical profile and allowable program services. In addition, many of these specialized services are also available as traditional State Plan or EPSDT services.

The state's process for heightened scrutiny, reviewing settings presumed to be non-HCB and determining if they warrant CMS' heightened scrutiny review, will be part of the onsite review process. Settings and issues will be initially identified through the desk review of member and provider survey responses. Specifically, responses that note a setting is on the grounds of or adjacent to a public institution or appear to be isolating in nature (based upon responses to the community access and integration service category) will be targeted for heightened scrutiny review. The state's process will be consistent with the CMS heightened scrutiny process. The state will submit a request, with sufficient evidence, to CMS for heightened scrutiny review of all settings presumed to be non-HCB (i.e. settings that are institutional or isolating in nature), but that the state believes are appropriate settings for HCBS and that have the qualities of HCB settings.

Ongoing Monitoring

The Global Commitment Demonstration and State statute allows the Department of Vermont Health Access (DVHA) to function as a Public Managed Care Entity. The Agency of Human Services (AHS) in its role as the Single State Agency is responsible for ensuring that all public managed care functions are clear and properly executed. To effectively and efficiently operate the program DVHA partners with other State Agencies to operate the program using Medicaid Managed Care Rules. In the case of Choices for Care, Developmental Services, and Traumatic Brain Injury, all operational oversight is provided by the Department of Disabilities Aging and Independent Living (DAIL). Thus DAIL, through the DVHA/DAIL partnership and State statute is the entity responsible for on-going monitoring of compliance. In the case of Community Rehabilitation and Treatment and Enhanced Family Treatment, all operational oversight is provided by the Department of Mental Health (DMH). Thus DMH, through the DVHA/DMH partnership and State statute is the entity responsible for on-going monitoring of compliance.

The state will monitor progress on Corrective Action Plans and will also begin routine monitoring of compliance with the requirements of the new rules during the Transition period for providers for whom no Corrective Action Plan is in effect. Monitoring of compliance with the HCBS Final Rule will occur long after the March 17, 2019, federal implementation date. On an ongoing basis, the state will ensure effective monitoring of provider settings to support continued compliance with all applicable HCB settings requirements. The Vermont MCE will have primary operational responsibility for monitoring, with oversight from AHS and an External Quality Review Organization. MCE staff will monitor member experience and compliance with HCB settings requirements by modifying its current monitoring/oversight tools to include the new HCBS requirements. If the MCE identifies a compliance issue during a review, the provider will be notified of the issue and remediation measures will be taken, including but not limited to the development of a CAP, to address the issue. The provider will submit periodic updates to the MCE on the status of implementation. AHS and an External Quality Review

Organization will be responsible for overseeing the MCE and will ensure that they adhere to all applicable CMS guidance.

Relocation Plan and Process

The state has no plans to remove any of the current services from the system and is committed to supporting the needs and preferences of individuals within the requirements of the HCBS final regulations. If a provider is found deficient in any area, the State will work with them, through a corrective action process, to improve the quality of care and the setting characteristics to align with State and federal HCBS standards. During this time, participants will have the choice of continuing to receive services from the provider while the provider implements corrective action to bring the setting into compliance or transition to a new provider. In the event of a transition, the state will work with the individual and his/her family/caregiver and provider (existing and new), etc. to develop a smooth transition process that will ensure continuity of care and protect the health and welfare of the individual throughout the process. Through the person-centered planning process, the state will ensure that members make an informed choice from alternative settings that comply with the HCB settings requirements and will provide the necessary supports. Should the State determine that a setting cannot or will not meet required standards; a review of the individualized plan of care for each Specialized Program enrollee living in that setting would occur. Planning would include a discussion of needs and preferences with each participant. The person and their team would locate another suitable setting within the community. Transition planning and notice would occur based on the individual's clinical needs. In communities where no other options exist, the State may, at its discretion, seek qualified providers through procurement or other designation processes.

Vermont Global Commitment to Health Comprehensive Quality Strategy

I. INTRODUCTION

The Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint or road map for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it sets forth specifications for quality assessment and performance improvement activities that the Agency of Human Services (AHS) will implement to ensure the delivery of quality health care. The Centers for Medicare and Medicaid Services (CMS) published its final rule related to Home and Community Based Services (HCBS) for Medicaid-funded long term services and supports provided in residential and non-residential home and community-based settings. The final rule took effect March 17, 2014. The CQS identifies the framework and strategy for achieving and maintaining compliance with the federal HCBS requirements for all applicable Vermont HCBS programs. Rather than developing a transition plan – Vermont has opted to have the CQS demonstrate the state's compliance with the HCBS requirements and should suffice as the Statewide Transition Plan.

Managed Care Goals, Objectives and Overview

Medicaid Managed Care in Vermont

For more than two decades, the state of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which later in 1992 became part of the state-federal Medicaid program. When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300% of the Federal Poverty Level (FPL). In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both Demonstration populations paid a modest premium on a sliding scale based on household income. The VHAP waiver also included a provision recognizing a public managed care framework for the provision of services to persons who have a serious and persistent mental illness, through Vermont's Community Rehabilitation and Treatment program. While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program. Recognizing that it could not spend its way out of projected deficits, Vermont worked in partnership with CMS to develop two new innovative 1115 demonstration waiver programs, Global Commitment to Health (GC) and Choices for Care (CFC). Both demonstrations have enabled the State to preserve and expand the affordable coverage gains made in the prior decade; provide program flexibility to more effectively deliver and manage public resources; and improve the health care system for all Vermonters.

Global Commitment to Health Overview

The Vermont Global Commitment to Health Medicaid Section 1115(a) Demonstration was originally approved on September 27, 2005, and implemented on October 1, 2005. The Global Commitment to Health Section 1115(a) Demonstration is designed to use a multi-disciplinary approach to comprehensive Medicaid reform, including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility.

As of January 1, 2017, Vermont and CMS extended the Global Commitment to Health Demonstration to further promote delivery system and payment reform to meet the goals of the State working with the Center for Medicaid and CHIP Services, and the Center for Medicare and Medicaid Innovation (CMMI). Consistent with Medicare's payment reform efforts the Demonstrations allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Since 2005, the Global Commitment to Health Demonstration has reduced Vermont's uninsured rate from 11.4 percent in 2005 to approximately 2.7 percent in 2015 through expansion of eligibility and other Accountable Care Act reforms. The Demonstration has also enabled Vermont to address and eliminate bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Need Groups under the Choices for Care component of the Demonstration.

Due to the expansion of eligibility under the Vermont State Plan, pursuant to the Affordable Care Act, expansion of eligibility is no longer the primary focus of the Demonstration. However, the Demonstration continues to promote delivery system reform and cost-effective community-based services as an alternative to institutional care. The State's goal in implementing the Demonstration is to improve the health status of all Vermonters by:

- Promoting delivery system reform through value based payment models and alignment across public payers;
- Increasing access to affordable and high quality health care by assisting lower-income individuals who can qualify for private insurance through the Marketplace;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based (HCBS) alternatives recognized to be more cost-effective than institutional based supports.

The State employs four major elements in achieving the above goals:

1. ***Program Flexibility***: Vermont has the flexibility to invest in certain specified alternative services

and programs designed to achieve the Demonstration's objectives (including the Marketplace subsidy program).

2. ***Managed Care Delivery System***: Under the Demonstration the Agency for Human Services (AHS) executes an annual agreement with the Department of Vermont Health Access (DVHA), which delivers services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined by the Special Terms and Conditions (STCs).

3. ***Removal of Institutional Bias***: Under the Demonstration, Vermont provides a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level of care requirements.

4. ***Delivery System Reform***: Under the Demonstration, Vermont supports systemic delivery reform efforts using the payment flexibility provided through the Demonstration to create alignment across public and private payers.

   The initial Global Commitment to Health and Choices for Care Demonstrations were approved in September of 2005 and became effective October 1, 2005. The Global Commitment to Health Demonstration was extended for three years, effective January 1, 2011, and again for three (3) years, effective October 2, 2013. The Choices for Care Demonstration was extended for five (5) years effective October 1, 2010, and became part of the Global Commitment to Health Demonstration in January 2015. The following amendments have been made to the Global Commitment to Health Demonstration:

   - 2007: A component of the Catamount Health program was added, enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost-effective employer-sponsored insurance, as determined by the state.

   - 2009: The State extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

   - 2011: The State included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

   - 2012: CMS provided authority for the State to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

   - 2013: CMS approved the extension of the Global Commitment to Health Demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the New Adult Group under the State Plan to the

population affected by the Demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: In January 2015, the Global Commitment to Health Demonstration was amended to include authority for the former Choices for Care Demonstration. In addition, the State received Section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

Demonstration Goals

The State's high-level goal for all health reforms is to create an integrated health system able to achieve the Institute of Medicine's "Triple Aim" goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost.[1] This is supported in the Global Commitment to Health Demonstration through supporting innovative delivery system reforms, including Medicaid Accountable Care Organizations (ACO) and the development of progressive in-home and community based services and supports that are cost-effective and support persons who have long-term care service and support needs, complex medical, mental health and/or substance use disorder treatment needs. Overarching Demonstration goals are described below:

- ***To increase access to care***: All enrollees must have access to comprehensive care, including financial, geographic, physical, and communicative access. This means having health insurance, appropriate providers, timely access to services, culturally sensitive services, and the opportunity for second opinions as needed.

- ***To contain health care cost***: Cost-effectiveness takes into consideration all costs associated with providing programs, services, and interventions. It is measurable at the category-of-service, individual enrollee, aid category, and aggregate program levels.

- ***To improve the quality of care***: Quality refers to the degree to which programs/services and activities increase the likelihood of desired outcomes. The six domains necessary for assuring quality health care identified by the Institute of Medicine (IOM, 2001) are:
  - *Effectiveness*: Effective health care provides evidence-based services to all who can benefit, refraining from providing services that are not of benefit.
  - *Efficiency*: Efficient health care focuses on avoiding waste, including waste of equipment, supplies, ideas, and energy.
  - *Equity*: Equal health care provides care without variation in quality due to gender, ethnicity, geographic location, or socioeconomic status.
  - *Patient Centeredness*: Patient-centered care emphasizes a partnership between provider and consumer.
  - *Safety*: Safe health care avoids injuries to consumers from care that is intended to help.
  - *Timeliness*: Timely health care involves obtaining needed care and minimizing unnecessary delays in receiving care.

[1] Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academy Press, Institute of Medicine; 2001.

- ***To eliminate institutional bias:*** By allowing specialized program participants choices in where they receive long-term services and supports and by offering a cost-effective array of in-home and community services for older adults, people with serious and persistent mental illness, people with developmental disabilities and people with traumatic brain injuries who meet program eligibility and level of care requirements.

Elements

- The Quality Strategy includes, at a minimum, information relating to the following issues:The MCO and PIHP contract provisions that incorporate the standards of Part 438, subpart D;
- Procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs;
- Procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee;
- Procedures that regularly monitor and evaluate the MCO and PIHP compliance with the standards of Part 438, subpart D
- Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this Part 438;
- An information system that supports initial and ongoing operation and review of the State's quality strategy; and
- Standards, at least as stringent as those in Part 438, subpart D, for access to care, structure and operations, and quality measurement and improvement.

Specialized Programs

Under the GC Demonstration, Vermont is authorized to provide an array of cost-effective in-home and community services. Providers of these services must meet designation, certification and/or additional licensing requirements to be approved by the State to serve the most vulnerable of Vermont's citizens. These specialized programs are designed to support a unique group of beneficiaries, each is outlined below.

- *Choices for Care*: long-term services and supports for persons with disabilities and older Vermonters. The Demonstration authorizes HCBS waiver-like and institutional services such as: nursing facility; enhanced residential care; personal care; homemaker services; companion care; case management; adult day services; and adult family care.

- *Developmental Disability Services*: provides long-term services and supports for persons with intellectual disabilities. The Demonstration authorizes HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care.

- *Traumatic Brain Injury Services*: provides recovery oriented and long-term services and supports for persons with a traumatic brain injury. The Demonstration authorizes HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.

- *Enhanced Family Treatment*: provides intensive in-home and community treatment services for children who are experiencing a severe emotional disturbance and their families. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports.

- *Community Rehabilitation and Treatment Program*: provides recovery oriented, in-home and community treatment services for adults who have a severe and persistent mental illness. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports.

  Through a special provision as a Designated State Health Program, Community Rehabilitation and Treatment benefits can be extended to individuals with severe and persistent mental illness with incomes between 133 and 150 percent of the federal poverty level, under the Demonstration.

Demonstration Hypotheses

The State has identified the following overarching hypotheses for the Demonstration.

- The Demonstration will result in improved access to care;
- The Demonstration will result in improved quality of care;
- Value-based payment models will promote access to care and appropriate use of resources;
- Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
- Improved access to primary care will result in positive health outcomes;
- Enhanced care coordination will promote timely access to needed care;
- The Demonstration will result in enhanced community integration;
- The Demonstration will maintain or reduce spending in comparison to what would have been spent absent the Demonstration;

Medicaid Managed Care Program Objectives

The objectives reflect the state's priorities and areas of concern for the population covered by the Managed Care Entity (MCE) contract. Results of prior program experience, performance measurement, External Quality Review Organization (EQRO), and other quality related reporting activities will help to identify the quality strategy priority areas.

Table 4: Quality Strategy Priority Areas:

Priority Area	Objective w/Target	Time Frame
Access to Care	AHS will demonstrate a 5% improvement in Preventive care visits of Medicaid managed care beneficiaries over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in the rate of adolescents receiving well care visits over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in the rate of Well-Child Visits in the First 15 Months of Life over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in the rate of Well-Child	1/1/2017-

	Visits in the Third, Fourth, Fifth, and Sixth Years of Life over the next five years.	12/31/2021
	AHS will demonstrate a 5% improvement in enrollee access to dental visits over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in follow-up after hospitalization for mental illness (7 day and 30 day) over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in Children and Adolescents' Access to Primary Care Practitioners over the next five years.	1/1/2017-12/31/2021
Prevention	AHS will demonstrate a 5% improvement in enrollee chlamydia screening in women over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in enrollee breast cancer screening over the next five years..	1/1/2017-12/31/2021
Chronic Conditions	Medication Management for People with Asthma over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in Initiation and engagement of alcohol and other drug dependence treatment over the next five years.	1/1/2017-12/31/2021
Health Outcomes	AHS will demonstrate a 5% improvement in controlling enrollee high blood pressure over the next five years.	1/1/2017-12/31/2021
Enhanced Care Coordination	Blueprint, VCCI, and ACO measures TBD	1/1/2017-12/31/2021
Community Integration	Community access, choice and control, and employment measures TBD	1/1/2017-12/31/2021

* Targets to be identified by the waiver measures work group by December 31, 2017.

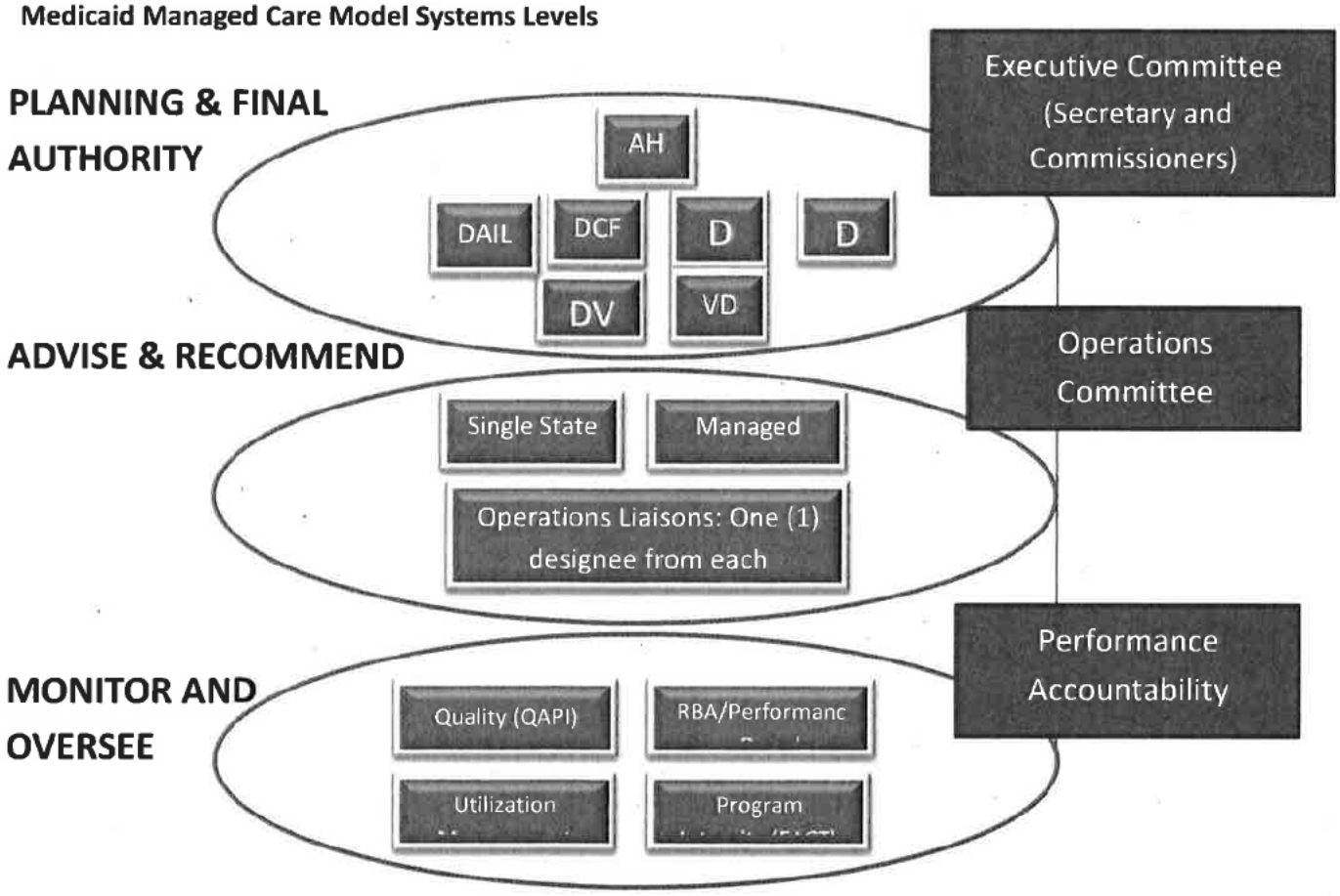
Overview of the Quality Management Structure

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations, found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid Managed Care requirements. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the GC Demonstration, DVHA has modified operations to meet Medicaid managed care requirements. This includes requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance and quality improvement. Per the External Quality Review Organization's findings, DVHA has achieved exemplary compliance rates in meeting Medicaid managed care requirements. Additionally, in its role as the designated unit responsible for operation of the traditional Medicaid program (including long term care, SCHIP and DSH), DVHA is responsible for meeting requirements defined in federal regulations at 42 CFR 455 for those services excluded from the GC Demonstration. Each state Medicaid agency contracting with a MCE is required to develop and implement a written strategy for assessing and improving the quality of managed care services. The strategy must comply

with the provisions issued in the Code of Federal Regulations (CFR). Under the current waiver structure, AHS pays DVHA a per member per month (PMPM) estimate using prospectively derived actuarial rates for the waiver year. This capitation payment reflects the monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the underlying GC expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similarly to those used by state Medicaid agencies that contract with traditional managed care organizations to manage some or all of the Medicaid benefits. It is believed that the use of a managed care system will allow Vermont to purchase the best value health care for Medicaid beneficiaries, improve access to services for underserved and vulnerable beneficiary populations, and protect them from substandard care.

The need for AHS-wide cross-departmental teams has been identified for three core areas. These include Executive, Operations, and Performance Accountability. Each team is facilitated by an AHS senior staff member and/or senior managers from departments and divisions impacted by Global Commitment. These teams are responsible for ensuring that necessary changes in internal operations occur related to the DVHA/MCE work plan, IGA commitments and other relevant state and federal regulations. The AHS Performance Accountability Committee (PAC) is charged with the development, integration, and maintenance of a Comprehensive Quality Strategy (CQS), generating AHS -wide quality standards for access to care, structure and operations, and quality measurement and improvement that comply with Title 42 of the Code of Federal Regulations sections 438.206 – 438.236. Additionally, this group will make recommendations to the Secretary's Office regarding the overall AHS direction related to quality and outcome measurement. The CQS supports the authority and responsibility of AHS for the development and implementation of effective management of the Quality Strategy.

Medicaid Managed Care Model Systems Levels



Executive Committee

Purpose: The primary purpose of the Agency of Human Services (AHS) Medicaid Managed Care Model Executive Committee is to establish and convey a clear vision and strategy for the system that is understood by all stakeholders and communicated within every organizational unit.

Standing Committee Membership: The Executive Committee shall be composed of the AHS Secretary and all AHS Department Commissioners.

Chair: The Committee chair shall be the AHS Secretary.

Process: The Committee shall meet as often as necessary to carry out its governance responsibilities, but a minimum of three (3) times a year. The Committee shall formally respond to the Operations Committee regarding all recommendations submitted by the Operations Committee.

Responsibilities: The Committee holds final authority on all matters relating to the Global Commitment to Health waiver (including investments) and all new initiatives that impact health care reform and funded by Medicaid. The Committee shall develop rules for decision making (by-laws) and set formal procedures (e.g., Roberts Rules of Order or Joint Consensus).

Operations Committee

Purpose: The primary purpose of the Agency of Human Services (AHS) Medicaid Managed Care Model Operations Committee is to ensure that policies and policy changes are aligned with the health care reform vision and strategies and are in compliance with the Agency's agreement with CMS under the Special Terms and Conditions (STC) of the Global Commitment to Health waiver.

Standing Committee Membership: The Committee shall be composed of at least three (3) standing members from AHS and three (3) members from the Department of Vermont Health Access (DVHA).

Expanded Committee Membership: The Commissioner from each AHS department shall appoint an *Operations Liaison* to the Committee who is a senior policy and program leader.

Chair: The Secretary of the Agency of Human Services shall appoint an Operations Committee chair who will report the Operations Committee's recommendations to the Executive Committee.

Process: The Committee shall meet as often as necessary to carry out its governance responsibilities, but a minimum of three (3) times a year. Following each meeting, the Committee chair shall provide a report to the Executive Committee. Reports shall include the following elements: an overview of actions since the last Operations Committee report; a broad overview of current projects, including the status of goals and whether timelines are being met, and; any recommendations for future plans.

Responsibilities: The Committee is responsible for advising and providing recommendations to the Executive Committee. It connects the Agency's work to its vision and strategy by addressing the needs of stakeholders. The Committee shall develop rules for decision making and set formal procedures. Examples of Operations Committee work include but are not limited to the following: assistance with waiver renewals; recommendations on quality improvement initiatives and/or compliance issues; IGA renewals, and; reviewing new strategies, policies and procedures intended to enhance the effectiveness of AHS's interactions with physicians, hospitals and other provider community constituents.

Performance Accountability Committee

Purpose: The primary purpose of the Agency of Human Services (AHS) Medicaid Managed Care Model Performance Accountability Committee is to oversee and monitor the operations of the Managed Care model, ensuring its practices are aligned with the health care reform vision and strategies and are in compliance with the Agency's agreement with CMS under the Special Terms and Conditions (STC) of the Global Commitment to Health waiver.

Standing Committee Membership: The Committee shall be composed of DVHA and AHS management and program staff who are responsible for ensuring that quality and value of care for the beneficiary population meet or exceed the Agency's vision and values and align with the strategic plan and the Global Commitment to Health STCs.

Expanded Committee: The Commissioner from each AHS department shall appoint ad hoc Committee members who are policy and program leaders to address specific needs and complete specific tasks or projects. These ad hoc members will remain on the Committee for the duration of their assignments.

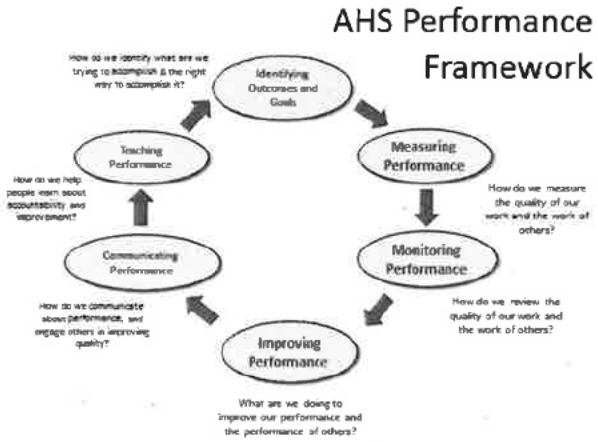
Chair: The Operations Committee chair shall appoint a Performance Accountability chair who will report the Committee's recommendations to the Operations Committee.

Process: The Committee shall meet as often as necessary to carry out its responsibilities under this plan, but a minimum of six (6) times a year. Following each meeting, the Committee chair shall provide a report to the Operations Committee. Reports shall include the following elements: an overview of actions since the last Performance Accountability Committee report; a broad overview of current projects, including the status of goals and whether timelines are being met, and; any recommendations for future plans.

Responsibilities: The Committee is responsible for advising and providing recommendations to the Operations Committee. It is responsible for monitoring quality and compliance for the Managed Care model. The Committee shall develop rules for decision making and set formal procedures. Examples of work include but are not limited to the following: reviewing results of EQRO audits and providing recommendations for continuous improvement; developing and monitoring utilization management, quality improvement, program integrity, and compliance plans, and; oversight of existing programs.

AHS Performance Framework

The AHS Performance Framework identifies the key/critical components of an AHS quality/performance management system. The development of the system was guided by - and intentionally incorporates - many of the principles associated with Results Based Accountability (RBA) to ensure synergy with the State's roll-out.



The Agency of Human Services Performance Framework outlines the key components of our continuous improvement strategy to improve outcomes for the people we serve. Each component in the Performance Framework encompasses a range of strategies, practices, processes, and activities happening within each Department and across the Agency. The AHS Performance Framework enables us to better understand and strengthen our mechanism for remaining accountable for improving conditions of well-being for the Vermonters we serve.

The Framework is based on the understanding that in order to pursue our mission and accomplish our goals, we must actively and continually measure our performance, monitor our progress, and improve our strategies based on what we've learned - from employee evaluations and professional development,

the success of our biggest programs, to the effectiveness of our administration. In order to embed continuous improvement as a practice into the Agency culture, we must also communicate about our progress, and help teach others about accountability and how we can work together to improve conditions of well-being in Vermont.

State and Provider Responsibilities

The Single State Agency, AHS, retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 1(a)(vii)(2) - as well as the health and welfare of enrollees.

Development & Review of Quality Strategy

The State of Vermont will use a process to develop, review and revise its CQS that includes internal meetings with key decision makers and external meetings with stakeholders (i.e. beneficiaries, advocacy groups and providers). The Performance Accountability Committee (PAC) was designed to build strategic partnerships among department stakeholders, obtain input, and build consensus on the state's quality assessment and improvement activities as well as increase their understanding of the requirements of the CFR and State. The PAC will review the effectiveness of this strategy on an annual basis. The CQS will use both qualitative and quantitative methods to collect data designed to assess the impact of the Quality Strategy. AHS will assess the Quality Strategy objectives using HEDIS results, CAHPS and other consumer survey results, and the EQRO Technical Report Strengths and Opportunities for Improvement section. AHS considers a change in reporting to be significant enough for stakeholder review when the numbers, types, or timeframes of reporting are revised. AHS will report strategy updates to CMS at least annually.

Public Engagement

Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii). The State will solicit and obtain the input of beneficiaries, the Medicaid and Exchange Advisory Board (MEAB), and other stakeholders in its development. Prior to submission of the CQS, the state will:

–Allow a minimum of a 30-day public comment period on the Draft CQS

–Consider public comments and modify the Draft CQS accordingly

–Submit evidence of public comment and our response to comments

Public meeting notices will be advertised in local newspapers and on posted on state websites. In addition, public meeting notices will be distributed to beneficiary and provider stakeholder groups and organizations. Information on the AHS website will include a summary of the new federal rule, the CQS, and provid the mailing address and e-mail address for submission of public responses, comments and input to the CQS. A summary of the comments received and the state's response to these comments will be shared with CMS. The state's final CQS including revisions based on the receipt of public comments will be posted on the AHS website concurrent with submission to CMS.

II. ASSESSMENT

1. Quality and Appropriateness of Care

Vermont assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through: State Internal monitoring, Quality Indicators monitoring; PIPs, Compliance with federal and state regulations, and EQRO activities, including the EQRO Annual Report. Demonstrating success and identifying challenges in meeting objectives of managed care are based on data that reflects: health plan quality performance, access to covered services, extent and impact of care management, use of person-centered care planning, and enrollee satisfaction with care. Measures used in this approach include but are not limited to The National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and consumer satisfaction surveys including the Consumer Assessment Health Care Provider Systems (CAHPS) survey.

Definition of special health care needs.

The MCE is required to establish and maintain policies and procedures to identify and coordinate health care services for members with special health care needs. Participants in the following programs are identified by the state as having special health care needs:

- Developmental Services, Traumatic Brain Injury, Choices for Care MLTSS program (DAIL)
- Community Rehabilitation and Treatment and Enhanced Family Treatment (DMH)

For each enrollee that the managed care entity confirms as having special health care needs, the individual is assigned a care coordinator. In addition to facilitating the development of a multidisciplinary service plan, the care coordinator is also responsible for coordinating service among providers, monitoring the treatment plan, and providing periodic reassessments. The MCE defines individuals with special health care needs and is able to identify such enrollees through information contained in Health Risk Assessments; special application for service (e.g., DS, CMH, TBI, etc.), claims data review, or any other available data source.

2. National Performance Measures

Vermont AHS requires DVHA to report performance measures. A number of the measures are part of the CMS core performance measures for children and adult in Medicaid and CHIP.

Population Specific Metrics

This section includes information on population specific metrics for each population covered by the Medicaid program, including children, individuals with mental illness, non-disabled adults, individuals receiving home and community services (HCBS), and individuals receiving long term services and supports (Choices for Care).

Table 5: Population Specific Measures

POPULATION	MEASURES	TARGET	CY2016 RATE
Children	Adolescent Well-Care Visits (AWC)	49.2%	46.85%
	Children and Adolescents' Access to Primary Care Practitioners (CAP)	TBD	TBD
	Well-Child Visits in the First 15 Months of Life (W15) 6 or more visits	70.75%	67.38%
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	76.23%	72.6%
	Annual Dental Visit (ADV) Total	68.11%	64.87%
Adults	Breast Cancer Screening (BCS)	56.93%	54.22%
	Chlamydia Screening in Women (CHL)	55.15%	52.52%
	Adults' Access to Preventive/Ambulatory Health Services (AAP) Total	79.57%	75.78%
	Medication Management for People with Asthma (MMA) Total	74.68%	71.12%
Mental Illness	Follow-Up After Hospitalization for Mental Illness (FUH) 7 and 30 days	45.27% & 62.53%	43.11% & 59.55%
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	36.74% & 15.04%	34.99% & 14.32%
Choices for Care (CFC)	*Ambulatory Care*	TBD*	TBD*
Developmental Disability Services (DS)	*Ambulatory Care*	TBD*	TBD*
Traumatic Brain Injury (TBI)	*Ambulatory Care*	TBD*	TBD*
Community Rehabilitation and Treatment (CRT)	*Ambulatory Care*	TBD*	TBD*

* Targets and benchmarks (where applicable) will be identified by the waiver measures work group by December 31, 2017.

Metrics are measured at the following levels of aggregation: the state Medicaid agency, specific health care program (such as Choices for Care), and potentially at each direct health services provider. The metrics are aligned with the Medicaid and CHIP adult and child core measures, and also align with other existing Medicare and Medicaid federal measure sets where possible and appropriate. In addition, the metrics go beyond HEDIS and CAHPS data, and reflect cost of care. The state will work with CMS to further define metrics, as appropriate, for collection.

3. Monitoring, Compliance, and Evaluation

The Agency of Human Services (AHS) uses two main sources of information to determine compliance with CMS requirements: 1) document review and 2) interviews with MCE personnel.

Document Review

AHS will monitor MCE compliance with standards using desk audits and an on-site review process. Typically, an onsite visit will begin with a review of documents. Prior to the onsite visit, the MCE will receive a list of documents needed for review. This will be accompanied by instructions on how to organize and prepare the documents for the reviewers. These instructions will request that documents remain available to reviewers for the duration of the onsite visit. Reviewers might request the MCE to provide an orientation to the organization of their documents. Also prior to the onsite visit, reviewers might request reports on previous reviews and subsequent MCE corrective actions in order to identify areas on which the reviewers might need to focus the current monitoring.

During document review, reviewers begin the assessment of compliance with regulatory provisions, and issues that will be pursued during interviews. MCE staff does not need to be present during this onsite activity, but should be available if reviewers have questions or difficulty locating a particular document or item of information.

During the review of documentation, reviewers will conduct the following:

- Take notes that will assist in making determinations about compliance with the regulatory provisions;
- Identify topics or issues that need clarification or follow-up during interviews;
- Identify items of information that were not available or located in documents to provide the MCE an opportunity to respond; and
- Identify specific document content for discussion at an interview to provide the MCE an opportunity to prepare participants with copies or to identify additional participants that may be necessary for the discussion.

Interviews

While document review is an important part of determining compliance, understanding the document content and performance of procedures outline in the documents typically can only be determined by talking with MCE personnel. Therefore, interaction with MCE staff is required to obtain a complete picture of the degree of compliance with requirements. Interviews provide clarification. They can reveal the extent to which what is documented is actually implemented. Interviews also provide an opportunity to explore any issues that were not fully addressed in documents, and also provide a better understanding of MCE performance.

Internal Monitoring

Onsite visits are an effective method for performing monitoring activities such as document review and interviews. Early contact and communication with the MCE is necessary to plan an efficient and effective survey and therefore is a crucial step in arranging and conducting an onsite evaluation. A communication plan and expectations should be outlined and followed to the extent possible. Prior to

receiving an onsite visit, the MCE should be provided with information such as: the scope of the evaluation to be performed, how the evaluation will be conducted, lists of documents that need to be available, instructions for the organization and presentation of documents, completion of any forms or other data gathering instruments, expected interview participants, administrative arrangements, and other expectations or responsibilities.

Home and Community Based Service (HCBS)

Special focus is placed on long term care services and supports (CFC) populations and addresses the following:

1. A self-assessment of CFC adherence to state and federal standards of care to include:
   i. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population.
   ii. Examination of processes to identify any potential corrective action steps toward improving the CFC system.
2. Person-Centered Planning and Integrated Care Settings
3. Comprehensive and Integrated Service packages
4. Qualifications of Providers
5. Participant Protections

The MCE must determine whether services in these settings meet the community standards set forth in the rules. Initial and ongoing compliance with standards will include, but not be limited, to the following methods: licensing reviews, provider qualification reviews, site visits, survey of individuals in receipt of HCBS, provider self-assessment, or a sample of settings. If necessary, CMS will allow Vermont up to four years to phase in these changes. All such services will be in compliance with CMS requirements before March 2019.

4. External Quality Review (EQR)

The Vermont Agency of Human Services (AHS) meets this requirement by contracting with Health Services Advisory Group, Inc. (HSAG), an EQRO, beginning in contract year (CY) 2007–2008 to conduct the three Centers for Medicare & Medicaid Services (CMS) required activities (i.e., validation of performance measures, validation of performance improvement projects, review of compliance with standards) and to prepare the EQR annual technical report bringing together the results from the activities it conducted.

External Oversight

In addition to the internal oversight activities described above, the MCE is required to participate in the annual external independent review of quality outcomes, timeliness of, and access to services covered under this strategy. AHS will contract with an External Quality Review Organization (EQRO) to conduct activities outlined in Subpart E of 42 CFR 438. The EQRO is used to review MCE compliance with AHS specified standards for quality program operations, validation of AHS-required performance measures, and validation of AHS required performance-improvement projects. The external review may include but not be limited to all of any of the following: medical record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators,

administrative data analysis and review of individual cases. The EQRO will submit a technical report to AHS which will be used to guide quality assessment and improvement efforts. The EQRO report will:

- Assess the MCE's strengths and weaknesses with respect to quality, timeliness and access to health care services
- Provide recommendations for improving quality of programs/services and care furnished by the MCE
- Evaluate the implementation and effectiveness of the Quality Strategy

III. STATE STANDARDS

1. Access Standards

This section includes a discussion of the standards that the state has established in the DVHA contract for access to care, as required by 42 C.F.R. Part 438, subpart D (i.e., *availability of services*, *assurances of adequate capacity and services*, *coordination and continuity of care*, and *coverage and authorization of services*). These standards relate to the overall goals and objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

Regulatory Reference	Brief Description
§438.68	**Network Adequacy**
§438.68(b)	Provider specific network adequacy standards and scope
§438.68(d)	Network adequacy exception request process
§438.68(e)	Publication of network adequacy standards
§438.206	**Availability of Services**
§438.206(b)(1)	Maintains and monitors a network of appropriate providers
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional
§438.206(b)(4)	Adequately and timely coverage of services not available in network
§438.206(b)(5)	Out-of-network providers coordinate with the MCE or PIHP with respect to payment
§438.206(b)(6)	Credential all providers as required by §438.214
§438.206(b)(7)	Timely access to family planning providers
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week
§438.206(c)(1)(iv)	Mechanisms to ensure compliance by providers
§438.206(c)(1)(v)	Monitoring of network providers to ensure compliance
§438.206(c)(2)	Culturally competent services to all enrollees
§438.206(c)(3)	Physical access, reasonable accommodations and accessible equipment for enrollees with physical or mental disabilities
§ 438.207	**Assurances of Adequate Capacity and Services**
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment
§438.207(b)	Documentation to demonstrate compliance with all §438.207 requirements
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, specialty care and LTSS
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution
§438.207(c)	Documentation annually and anytime there has been a significant change in operations that would affect capacity and services
§438.208	**Coordination and Continuity of Care**
§438.208(b)(1)	Each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating services accessed by the enrollee
§438.208(b)(2)	Coordinate services the enrollee receives: between settings of care; with the services the enrollee receives from any other MCE/PIHP; with the services the enrollee receives from fee-for-service Medicaid; with the services the enrollee receives from community and social support providers
§438.208(b)(3)	Make best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees

Regulatory Reference	Brief Description
§438.208(b)(4)	Share with other MCEs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment to prevent duplication of those activities
§438.208(b)(5)	Ensure maintenance and sharing of enrollee information in accordance with professional standards
§438.208(b)(6)	Privacy protections when coordinating care
§438.208(c)(1)	State mechanisms to identify persons who need LTSS or persons with special health care needs
§438.208(c)(2)	Mechanisms to assess enrollees with LTSS or special health care needs by appropriate health care and LTSS professionals
§438.208(c)(3)	LTSSS or special health care needs treatment/service plans developed by individuals meeting LTSS service coordination requirements and a person trained in person centered planning as defined in §441.301(c)(1) and (2) in consultation with the any providers caring for the enrollee and with enrollee participation ; approved in a timely manner; reviewed and revised at least annually and in accord with applicable state standards
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs
§438.210	**Coverage and Authorization of Services**
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition
§438.210(a)(4)	DVHA may place appropriate limits on a service, such as medical necessity
§438.210(a)(4)(i)	Limits based on criteria specified in the Medicaid State Plan
§438.210(a)(4)(ii)(A)	Ensure that services furnished can reasonably achieve their purpose
§438.210(a)(4)(ii)(B)	Ensure that services supporting persons with LTSS needs or on-going chronic conditions are reflective of enrollee need
§438.210(a)(4)(ii)(C)	Ensure that family planning services are provided in manner that enables the enrollee's freedom to choose the method of family planning to be used
$438.210(a)(5)	Specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Plan, statutes or regulations or other State policy and procedures
§438.210(b)(1)	DVHA and its subcontractors must have written policies and procedures for authorization of services
§438.210(b)(2)	DVHA must have mechanisms to ensure consistent application of review criteria for authorization decisions and authorize LTSS based in an enrollee's current needs and assessments and consistent with the person-centered service plan
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional
§438.210(c)	DVHA must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services

DVHA 42 CFR 438.68 Network Adequacy Requirements

These standards ensure that contract network is adequate to support services to enrollees in a timely and efficient manner. DVHA will maintain the following time, distance standards statewide for all services covered under the contract. Upon request, these standards will be made available at no cost to enrollees with disabilities in alternative formats or through the provision of auxiliary aids and services. Any DVHA requests for exceptions that have been approved by the State will be specified in the AHS/DVHA contract.

Travel time to services must not exceed the limits described below for all regions of the State:
Primary Care (Adult and Pediatric) – No more than 30 miles or 30 minutes for all enrollees from residence or place of business unless the usual and customary standard in an area is greater, due to an absence of providers. DVHA's network will include all Medicaid participating providers, which equates to approximately 80% all providers in the State of Vermont. However, if the travel time standard is exceeded in an area which contains a non-participating provider, DVHA will work aggressively to bring that provider into the network.

OB/GYN -

Behavioral Health (mental health and substance use disorder; adult and pediatric) -

Specialist (Adult and Pediatric) -

Hospitals – Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater, mental health services where access to specialty care may require longer transport time, and for physical rehabilitative services where access is not to exceed 60 minutes.

Pharmacy -

Pediatric Dental -

LTSS Providers (for provider types in which an enrollee must travel for services) -

Additionally, network adequacy standards, other than time and distance for LTSS providers that travel to the enrollee to deliver services include:

- At least one certified Home Health Agency serving Choices for Care program participants in each region;
- At least one Designated or Specialized Service Agency (DA/SSA) per region serving persons with developmental disabilities
- At least one certified provider of Traumatic Brain Injury Services per region

In establishing and maintaining this network, DVHA must consider the following:

- Anticipated enrollment in the *Global Commitment to Health Waiver*;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
- That services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- Number and types of providers required to furnish the contracted services;

- Number of providers who are not accepting new patients; and
- Geographic location of providers and *Global Commitment to Health Waiver* enrollees, considering distance, travel time, the means of transportation ordinarily available to enrollees, and whether the location(s) provide physical access for enrollees with disabilities;
- The ability of network providers to communicate in with Limited English Proficiency enrollees in their preferred language;
- The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for enrollees with physical and mental disabilities;
- The availability of triage lines or screening systems as well as tele-medicine, e-visits and/or other innovative technological solutions.

AHS Monitoring Activities: The AHS has implemented programs and processes to monitor and assure that members' access to care is not restricted. AHS will conduct a thorough analysis of providers to ensure that DVHA is able to provide access to health care services as required. AHS will review DVHA provider and geographic access data to determine compliance with this standard. The provider capacity data will contain information on the number and type of providers, anticipated enrollment, and actual and expected health care utilization. In addition to identifying the number of providers available by specialty and type, this data will also contain the number of PCPs and mental health practitioners accepting new Medicaid patients, as well as, those not accepting new Medicaid patients. Geographic access data will contain the geographic distribution of each primary, specialty, and behavioral health care and LTSS provider. Focus of the review will be on access to services (e.g., calculated distance for members to travel from their primary residence to PCPs, specialists, hospitals, etc., 24-hour availability of services, scheduling and wait times, types of transportation that members ordinarily use for each service area, number of providers with physical access for members with disabilities for each service area, and selection and assignment of primary care provider). By monitoring this data, AHS will ensure that there are sufficient numbers and types of health care resources available to Medicaid enrollees. In addition to the above, AHS will conduct the following activities:

- Review provider directory no less than biennially
- Review DVHA provider contracts and contracting and non-contracting provider selection criteria
- Review results of DVHA provider and/or enrollee survey re: geographic accessibility and physical accessibility of care

AHS will review data regarding regular and routine care appointments. AHS monitors this data to assure that there will be providers within the standards for distance and travel time. AHS will accomplish the above by conducting the following activities:

- Review survey data from enrollees/providers
- Review provider contracts, orientation, or enrollment documents
- Review new member materials, enrollee handbooks
- Review Grievance/Appeal data

DVHA 42 CFR 438.206 Availability of Services Requirements

These standards ensure that services covered under the Medicaid Plan are available and accessible to enrollees

Maintain a Network of Appropriate Providers
Consistent with the scope of its contracted services and 42 CFR 438.68 above, DVHA will maintain and monitor a network of appropriate providers, supported by written agreements, that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities

AHS monitoring activities: AHS will review DVHA provider and geographic access data to determine compliance with this standard. The provider capacity data will contain information on the number and type of providers, anticipated enrollment, and actual and expected health care utilization. In addition to identifying the number of providers available by specialty and type, this data will also contain the number of PCPs and mental health practitioners accepting new Medicaid patients, as well as, those not accepting new Medicaid patients. Geographic access data will contain the geographic distribution of each primary, specialty, and behavioral health care and LTSS provider. By monitoring this data, AHS will ensure that there are sufficient numbers and types of health care resources available to Medicaid enrollees. In addition to the above, AHS will conduct the following activities:

- Review provider directory no less than biennially
- Review DVHA provider contracts and contracting and non-contracting provider selection criteria
- Review results of DVHA provider and/or enrollee survey re: geographic accessibility and physical accessibility of care

Provide Beneficiaries with Direct Access to a Women's Health Specialist
DVHA must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

AHS Monitoring Activities: AHS will ensure that DVHA stipulates direct access to a women's health specialist by conducting the following activities:

- Review new enrollee materials or enrollee handbook
- Review provider directory no less than biennially (identifying women's health specialist)

Provide for a Second Opinion from a Network Provider
Global Commitment to Health enrollees served through the public insurance programs shall have the right to obtain a second opinion from a qualified health care professional, within the network of enrolled Medicaid providers. If needed, DVHA will arrange for the enrollee to obtain a second opinion by enrolling a qualified provider in the program, at no cost to the enrollee.

AHS Monitoring Activities: AHS will review IGAs to ensure that they provide for a second opinion from a qualified health professional. In addition, AHS shall conduct the following activities:

- Review provider agreements
- Review new member materials and enrollee handbooks

Provide for Services Not Available from a Network Provider
If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, DVHA must adequately and timely cover these services out of network for the enrollee, for as long as the DVHA provider network is unable to provide them.

> **AHS Monitoring Activities:** AHS will review IGAs to ensure that they provide for services that are not available. In addition, AHS will review DVHA's new member materials, enrollee handbooks, and other enrollee information materials

Out-of-Network Providers
DVHA will ensure that payment to out-of-network providers and cost to the enrollee is no greater than it would be if the services were furnished within the network.

> **AHS Monitoring Activities:** AHS will review DVHA's new member materials, enrollee handbooks, and other enrollee information materials to ensure that enrollee cost is no greater than it would be if the services were furnished within the network.

Demonstrate Providers Are Credentialed
DVHA shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the credentialing requirements established by AHS for the Medicaid program. At a minimum, DVHA shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

> **AHS Monitoring Activities:** AHS ensures compliance with these standards through review of provider contracts and survey data. To provide further assurance of compliance, AHS may also crosscheck a sample of executed provider agreements with the National Practitioner Data Bank for sanctions or licensure limitations.

Family Planning Providers
DVHA will ensure network providers include family planning providers sufficient ensure timely access to services for enrollees.

> **AHS Monitoring Activities:** AHS will review data regarding access to care and network adequacy to assure that sufficient family planning providers are available. AHS may also:
> - Review survey data from enrollees/providers
> - Review provider contracts, orientation, or enrollment documents
> - Review new member materials, enrollee handbooks
> - Review Grievance and Appeal data

Timely Access to Services
In addition to delivery system structure and organization, timeliness of services is central to provision of accessible care. DVHA must ensure that coverage is available to enrollees on a twenty-four hour per day, seven

day per week basis. Coverage may be delegated to the subcontracted Departments, but DVHA must maintain procedures for monitoring coverage to ensure twenty-four-hour availability as medically necessary.

DVHA shall require its providers to meet in-office waiting times for appointments do not exceed one hour, except in areas where a longer waiting time is usual and customary. Exceptions to the one-hour standards must be justified and documented to AHS on the basis of community standards.

Appointment availability shall meet the usual and customary standards for the community, and shall comply with the following:

- Urgent care: Within twenty-four hours;
- Non-urgent, non-emergent conditions: Within 14 days;
- Preventive Care: Within 90 days.

Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

DVHA must establish mechanisms to ensure that network providers comply with the timely access requirements; monitor regularly to determine compliance; and take corrective action if there is a failure to comply.

AHS Monitoring Activities: AHS will review data regarding regular and routine care appointments, urgent care appointments, and after-hours care. AHS monitors this data to assure that providers ensure timely access to services. AHS will accomplish the above by conducting the following activities:

- Review survey data from enrollees/providers
- Review provider contracts, orientation, or enrollment documents
- Review new member materials, enrollee handbooks
- Review Grievance/Appeal data

Access and Cultural Considerations

DVHA shall participate in AHS efforts to promote the delivery of services in a culturally competent manner to all *Global Commitment to Health Waiver* enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

AHS Monitoring Activities: AHS will assess the cultural, ethnic, racial and linguistic needs of Medicaid beneficiaries and make recommendations to DVHA to adjust the availability of practitioners within its network, if necessary. AHS will review IGAs to ensure that they stipulate culturally and linguistically appropriate care to members. AHS will also review new member materials, the enrollee handbook, and provider contracts to ensure compliance with this standard.

Physical Accessibility and Reasonable Accommodations

DVHA must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

AHS Monitoring Activities: AHS will review provider agreements, enrollee materials and IGAs to ensure that they stipulate accessibility and reasonable accommodation standards.

DVHA 42 CFR 438.207 Assurance of Adequate Capacity and Services Requirements

Documentation submitted by DVHA will demonstrate they offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees statewide. DVHA will maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees

DVHA shall update network capacity data annually and at any time there has been a significant change in the DVHA operations that would affect adequate capacity or services, including changes in services, benefits, geographic service areas, payments or enrollment of a new population.

> **AHS Monitoring Activities:** AHS shall review variable definitions used by DVHA to provide network capacity data. This activity will assess whether or not DVHA offers an appropriate range of covered services adequate for the anticipated number of enrollees for the service and that DVHA maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

DVHA 42 CFR 438.208 Coordination and Continuity of Care Requirements

Modern health care delivery systems are multi-faceted and involve complex interactions between many providers. Such delivery systems require coordination across the continuum of care. This standard requires that DVHA and its IGA partners implement procedures to deliver coordinated health care services and supports for all enrollees.

DVHA and its IGA Partners will implement policies and procedures to deliver and coordinate services for all enrollees. These procedures must meet the following requirements:

(1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;

(2) Coordinate the services furnished to the enrollee:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; and
- With the services the enrollee receives from community and social support providers.

(3) Provide best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful;

(4) Share with AHS and/or other entities serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;

(5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and

(6) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

Members with LTSS or Special Health Care Needs

DVHA is required to establish and maintain policies and procedures to identify and coordinate health care services for members with special health care needs. Participants in the following programs are identified by the state as having LTSS or special health care needs:

- Developmental Disability Services (DDS), Traumatic Brain Injury (TBI), Choices for Care (CFC) programs within DAIL
- Community Rehabilitation and Treatment (CRT) and Enhanced Family Treatment services for children with a Severe Emotional Disturbance (EFT) programs within DMH

DVHA and its IGA partners will assure that identification, assessment and care coordination services for enrollees with special health care needs or who need LTSS as defined by AHS are implemented. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements defined by AHS as appropriate. The treatment or service plan must be:

- Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;
- Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1) and (2);
- Approved in a timely manner;
- In accordance with any applicable AHS quality assurance and utilization review standards; and
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per 42 CFR §441.301(c)(3).

For enrollees with special health care needs who are determined through the assessment above to need a course of treatment or regular care monitoring, DVHA and its IGA partners must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

For each enrollee that DVHA and/or its IGA partners confirm as having special health care needs, the individual will be assigned a care coordinator. In addition to facilitating the development of a multidisciplinary service plan, the care coordinator is also responsible for coordinating service among providers, monitoring the treatment plan, and providing periodic reassessments.

DVHA and its IGA partners will identify such enrollees through information contained in Health Risk Assessments; special application for services (e.g., DDS, EFT, TBI, etc.); claims data review; or review of any other available data source.

AHS Monitoring Activities: In accordance with 42 CFR 438.208, DVHA with its sub-contractors must implement procedures to deliver and coordinate health care for all beneficiaries. AHS looks for the following elements to determine if DVHA has a basic system in existence: (1) beneficiaries must be assigned to Primary Care Medical Home, Advanced Primary Care Practice, Specialized Health Home, Accountable Care Organization or otherwise have a person or entity identified for coordination of services (2) persons with special health care or LTSS needs must receive case management services according to established State criteria and must receive the appropriate care; (3) DVHA must have IGAs with other appropriate agencies or institutions to coordinate care; and (4) DVHA and its IGA partners must monitor continuity of care across all services and treatment modalities. AHS will review the following documents to determine compliance with this standard:

- New member materials, enrollee handbooks

- Provider manuals and contracts
- Agreements between DVHA and its IGA partners

DVHA 42 CFR 438.210 Coverage and Authorization of Services Requirements

Coverage

The Global Commitment to Health Waiver includes a comprehensive health care services benefit package. The covered services will include all services that AHS requires be made available through its public insurance programs to enrollees in the Global Commitment to Health Waiver including all State of Vermont title XIX plan services in the following categories:

- Acute health care services
- Preventive health services
- Behavioral health services, including substance abuse treatment
- Specialized mental health services for adults and children
- Developmental services
- Pharmacy services
- School-based services
- LTSS

The monthly capitation limit established by AHS for DVHA, operating a managed care-like model, will include anticipated payment only for services specified in the Special Terms and Conditions under the Global commitment to Health Medicaid Demonstration.

Services will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid. DVHA will ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

DVHA may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

Authorization of Services

The term "service authorization request" means a Global Commitment to Health Waiver enrollee's request for the provision of a service, or a request by the enrollee's provider. DVHA and its IGA partners shall maintain and follow written policies and procedures for processing requests for initial and continuing authorization of medically necessary, covered services. The policies and procedures must conform to all applicable Federal and State regulations, including specifically that policies and procedures will:

- Have mechanisms to ensure consistent application of review criteria for authorization decisions;
- Consult with the requesting provider for medical services when appropriate;
- Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan; and
- Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

DVHA may require pre-authorization for certain covered services including, but not limited to, inpatient hospital admissions, home and community based services, and certain pharmaceutical products. For inpatient admissions, specific review criteria for authorization decisions is identified and outlined in the Acute Care Management Program Descriptions policies and procedures manual. DVHA will ensure consistent application

of review criteria for authorization decisions. Review Criteria shall be incorporated in the Utilization Management Plan.

For standard authorization decisions, the subcontracted Departments must reach a decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 14 calendar days from receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or the subcontracted Department justifies to DVHA a need for additional information and how the extension is in the enrollee's best interest.

For cases in which a provider indicates, or the subcontracted Department determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, the subcontracted Department must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. The 72 hours may be extended by up to 14 additional calendar days if the enrollee requests the extension, or if DVHA justifies to the State a need for additional information and how the extension is in the enrollee's interest.

Any case where a decision is not reached within the referenced timeframes constitutes a denial. Written notice must then be issued to the enrollee on the date that the timeframe for the authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.

Planned services will be identified by the authorized clinician working with the enrollee and under the direct supervision of a prescribing provider. Any decision to deny, reduce the range, or suspend covered services, or a failure to approve a service that requires pre-authorization, will constitute grounds for noticing the enrollee. Any disagreement identified by the enrollee at any interval of evaluation, will also be subject to notice requirements.

Notices must meet language format requirements set in the above section. Notice must be given within the timeframes set forth above, except that notice may be given on the date of action under the following circumstances:

- Signed written enrollee statement requesting service termination;
- Signed written enrollee statement requesting new service or range increase:
- An enrollee's admission to an institution where he or she is ineligible for further services;
- An enrollee's address is unknown and mail directed to him or her has no forwarding address;
- The enrollee's physician prescribes the change in the range of clinical need

DVHA or its IGA partner shall notify the requesting provider and issue written notices to enrollees for any decision to deny a service, or to authorize a service in an amount, scope or duration less than that requested and clinically prescribed in the service plan. Notices must explain the action DVHA or the IGA partner has taken or intends to take; the reasons for the action; the enrollee's right to a second opinion regarding the service decision, or at least, a clinical program director not involved in the service decision; the enrollee's right to file an appeal and procedures for doing so; circumstances under which an expedited resolution is available and how to request one; the enrollee's right at any time to request a Fair Hearing for covered services and how to request that covered services be extended; the enrollee's right to request external review by DVHA/AHS for covered services (as applicable to Medicaid eligibility) or alternate services; and the circumstances under which the enrollee may be required to pay the costs of those services pending the outcome of a Fair Hearing or external review by DVHA/AHS.

Service Limitation and Medical Necessity

DVHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, provided that:

- The services furnished can reasonably achieve their purpose, as required above;
- The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and
- Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20

DVHA determinations of ''medically necessary services'' must be no more restrictive than that used in the State Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. DVHA and its IGA partners are responsible for covering services that address the:

- Prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;
- Ability for an enrollee to achieve age-appropriate growth and development;
- Ability for an enrollee to attain, maintain, or regain functional capacity;
- Opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their choice.

Covered Outpatient Drug Decisions

All outpatient covered drug authorization decisions provide notice as described in Section 1927(d)(5)(A) of the Act.

Compensation for Utilization Management Activities

DVHA shall also develop and maintain a comprehensive Utilization Management Plan to identify potential over- and under-utilization of services. The Utilization Management Plan must conform to all applicable Federal and State regulations. DVHA shall not structure compensation for any entity that conducts utilization management services in such a way to provide incentives for the denial, limitation or discontinuation of medically necessary services to any enrollee.

AHS Monitoring Activities: AHS will review DVHA policies/procedures requiring licensed professionals to supervise all medical necessity decisions as well as written procedures specifying the type of personnel responsible for each level of UM decision making. In addition, AHS might also review written job descriptions with qualifications for practitioners who review denials of care based on medical necessity that requires: education, training or professional experience in medical or clinical practice and current license to practice without restriction. In addition, AHS shall conduct the following activities:

- Review DVHA/IGA Partner provider manuals
- Review grievance files or aggregate data related to payment/non-payment for services.
- Review the MCE's agreements with employees who perform utilization management activities.

2. Structure and Operations Standards

This section includes a discussion of the standards that the state has established in DVHA contract for structure and operations, as required by 42 C.F.R. Part 438, subpart D (i.e., *provider selection*, *enrollee information*, *confidentiality*, *enrollment and disenrollment*, *grievance systems*, and *sub contractual relationships and delegation*). These standards relate to the overall objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

Regulatory Reference	Brief Description
§438.214	**Provider Selection**
§438.214(a)	Written policies and procedures for selection and retention of providers
§438.214(b)(1)	Uniform credentialing and recredentialing policy that DVHA must follow
§438.214(b)(2)	Documented process for credentialing and recredentialing that DVHA must follow
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment
§438.214(d)	DVHA may not employ or contract with providers excluded from Federal health care programs
§438.10	**Enrollee Information**
§438.10 (c)(1)	Provide all enrollee information in a manner and format that is easily understood and readily accessible
§438.10 (c)(2)	Utilize the beneficiary support system as described in §438.71
§438.10 (c)(4-7)	Use definitions consistent with the State for managed care terminology and provide information consistent with all requirements in §438.10
§438.10 (d)(1-6)	Ensure oral interpretation and written materials are available in prevalent non-English languages and alternative formats; provide required enrollee notifications
§438.10(f)	Notice of termination of a contracted provider
§438.10(g)	Provide enrollee handbook meeting all requirements of §438.10(g)
§438.10(h)	Provide a provider directory consistent with all requirements in §438.10(h)
§438.10(i)	Provide a prescription coverage information and formulary information consistent with §438.10(i)
§438.224	**Confidentiality**
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements
§438.56	Enrollment and Disenrollment
§438.56	DVHA complies with the enrollment and disenrollment requirements and limitations in §438.56
§438.228	**Grievance Systems**
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner
§438.230	**Sub-contractual Relationships and Delegation**
§438.230(b)(1)	DVHA must oversee and be accountable for any delegated functions and responsibilities
§438.230(c)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or specify other remedies if the subcontractor's performance is inadequate; agreements will meet all requirements in §438.230

DVHA 42 CFR 438.214 Provider Selection Requirements

In accordance with 42 CFR 438.214, DVHA must implement written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, a process contracting with providers who have signed contracts or participation agreements with DVHA, that these policies and procedures and they do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. DVHA will follow the State's uniform credentialing and re-credentialing policies for acute, primary, behavioral, substance use disorders and LTSS providers. In addition, DVHA may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. Finally, DVHA must comply with the additional requirements established by the State listed below:

DVHA shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the requirements established by AHS for the Medicaid program. At a minimum, DVHA shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

DVHA agrees to ensure that network providers do not intentionally discriminate against *Global Commitment to Health Waiver* enrollees in the acceptance of patients into provider panels, or intentionally segregate Global Commitment to Health enrollees in any way from other individuals receiving services.

DVHA shall not knowingly have a relationship with either of the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

> **AHS Monitoring Activities:** AHS will review a sample of provider files and provider contract to determine the extent to which the standards are being implemented. In addition, AHS will review aggregate information and individual files of a sample of provider for whom DVHA has recently denied participation.

DVHA 42 CFR 438.10 Enrollee information Requirements

DVHA shall be responsible for educating individuals at the time of their enrollment into the *Global Commitment to Health Waiver*. Education activities may be conducted via mail, by telephone and/or through face-to-face meetings. DVHA may employ the services of an enrollment broker to assist in outreach and education activities.

DVHA shall provide information and assist enrollees in understanding all facets pertinent to their enrollment. All informational material will adopt uniform AHS definitions for identified managed care terms and include the following:

- What services are covered and how to access them
- Restrictions on freedom-of-choice
- Cost sharing
- Role and responsibilities of the primary care provider (PCP)
- Importance of selecting and building a relationship with a PCP
- Information about how to access a list of PCPs in geographic proximity to the enrollee and the availability of a complete network roster
- Enrollee rights, including appeal and Fair Hearing rights (described in greater detail below); confidentiality rights; availability of the Office of Health Care Ombudsman; and other beneficiary supports available under 42 CFR 438.71
- Enrollee responsibilities, including making, keeping, canceling appointments with PCPs and specialists; necessity of obtaining prior authorization (PA) for certain services and proper utilization of the emergency room (ER)

DVHA and AHS shall coordinate the development of the *Global Commitment to Health Waiver* enrollee handbook, which shall help enrollees and potential enrollees understand the requirements and benefits of the various programs available through the *Global Commitment to Health Waiver*. DVHA shall mail the enrollee handbook to all new enrollee households within 45 business days of determination of eligibility for the *Global Commitment to Health Waiver*. Enrollees may request and obtain an enrollee handbook at any time.

The enrollee handbook must be specific to the *Global Commitment to Health Waiver* and be written in language that is clear and easily understood by an elementary-level reader. The enrollee handbook must include a comprehensive description of the *Global Commitment to Health Waiver*, including a description of covered benefits, how to access services in urgent and emergent situations, how to access services in other situations (including family planning services and providers not participating in the Vermont Medicaid program), complaint and grievance procedures, appeal procedures (for eligibility determinations or service denials), enrollee disenrollment rights, and advance directives.

With respect to information on grievance, appeal and Fair Hearing procedures and timeframes, the *Global Commitment to Health Waiver* enrollee handbook must include the following information:

- Right to a State of Vermont Fair Hearing, method for obtaining a hearing, timeframe for filing a request, timeframes for resolution of the Fair Hearing, and rules that govern representation at the hearing;
- Right to file grievances and appeals;
- Requirements and timeframes for filing a grievance or appeal;
- Availability of assistance in the filing process;
- Toll-free numbers that the enrollee can use to obtain assistance in filing a grievance or an appeal including the Long-term Care Ombudsman and/or other advocates designated by the State to assist participants;
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for a State of Vermont Fair Hearing within the timeframes specified for filing; and that the enrollee may be required to pay the cost of any services furnished while the appeal is pending if the denial is upheld;

- Any appeal rights that the State of Vermont makes available to providers to challenge the failure of the DVHA to cover a service; and
- Information about Advance Directives and the service providers' obligation to honor the terms of such directives.

The following additional information must be included in the enrollee handbook:

- Information on specialty referrals;
- Information on accessing emergent and urgent care (including post-stabilization services and after-hours care) including what constitutes an emergency medical condition, that prior authorization is not required for emergency services and that the enrollee has the right use any hospital or other setting for emergency care;
- Information on enrollee disenrollment;
- Information on enrollee right to change providers;
- Information on restrictions to freedom of choice among network providers;
- Information on enrollee rights and protections, as specified in 42 CFR 438.100 ;
- Information on enrollee cost sharing;
- Additional information that is available upon request, including information on the structure of the *Global Commitment to Health Waiver* and any physician incentive plans; and Toll-free and TTY/TDY numbers for member services and any DVHA unit providing services directly to enrollees.

DVHA shall notify its enrollees in writing of any change that AHS defines as significant to the information in the *Global Commitment to Health Waiver* enrollee handbook at least 30 business days before the intended effective date of the change.

DVHA will provide to enrollees a provider directory for physicians, including specialists, hospitals, pharmacies, behavioral health providers and LTSS providers which will include the following information:

- The provider's name as well as any group affiliation.
- Street address(es).
- Telephone number(s).
- Web site URL, as appropriate.
- Specialty, as appropriate.
- Whether the provider will accept new enrollees.
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

The provider directory will be available in paper format upon request and must be updated at least monthly; electronic provider directories must be updated no later than 30 calendar days after DVHA receives updated provider information. Electronic provider directories must be made available on DVHA's web site in a machine-readable file and format.

DVHA will provider formulary information and will ensure that the following information about its formulary is available on their web site in a machine-readable file and format and provide;

- Which medications are covered (both generic and name brand); and
- Identify which tier each medication is on.

Accessibility of Enrollee Materials

DVHA will ensure that any information provided to enrollees electronically is:

- In a readily accessible format,
- Placed in a location on the Web site that is prominent and readily accessible,
- In an electronic form, which can be electronically retained and printed,
- consistent with the content and language requirements of 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and provided upon request within 5 business days.

All written materials for potential enrollees and enrollees must:

- Use easily understood language and format;
- Use a font size no smaller than 12 point;
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency; and
- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

DVHA shall comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. DVHA shall develop appropriate methods of communicating with its enrollees who do not speak English as a first language, as well as, enrollees who are visually and hearing impaired, and accommodating enrollees with physical disabilities and different learning styles and capabilities. Enrollee materials, including the enrollee handbook, shall be made available in all prevalent non-English languages. A prevalent non-English language shall mean any language spoken as a first language by five percent or more of the total statewide Global Commitment to Health Waiver enrollment.

DVHA shall ensure in-person or telephonic interpreter services are available to any enrollee who requests them, regardless of the prevalence of the enrollee's language within the overall program. AHS contracts with in-person and telephonic interpreter vendors, as well as, written translation vendors on behalf of DVHA and other departments under the AHS umbrella. DVHA will use these vendors as necessary and will bear the cost of their services, as well as the costs associated with making American Sign Language (ASL) interpreters and Braille materials available to hearing- and vision-impaired enrollees.

DVHA shall include information in the enrollee handbook on the availability of oral interpreter services, translated written materials, and materials in alternative formats. The Global Commitment to Health enrollee handbook shall also include information on how to access such services.

> **AHS Monitoring Activities:** AHS will review Enrollee Handbook annually, as well as, welcome packet and any updates as needed.

DVHA 42 CFR 438.224 Confidentiality Requirements

DVHA agrees that all information, records, and data collected with the agreement shall be protected from unauthorized disclosures. In accordance with section 1902(a)(7) of the Social Security Act, DVHA agrees to provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to

purposes directly connected with the administration of the plan. In addition, DVHA agrees to guard the confidentiality of recipient information, in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164. Access to recipient identifying information shall be limited by DVHA to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including AHS, the United States DHHS, and other individuals or entities as may be required by the State of Vermont.

Any other party may be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations, including 42 CFR 431, Subpart F pertaining to such access. AHS shall have absolute authority to determine if and when any other party shall have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

Nothing in this section shall be construed to limit or deny access by enrollees or their duly authorized representatives to medical records or information compiled regarding their case, or coverage, treatment or other relevant determinations regarding their care, as mandated by State and/or Federal laws and regulations.

> **AHS Monitoring Activities:** AHS will review provider contracts and partner IGAs for policies and procedures regarding the use and disclosure of any individually identifiable health information.

DVHA 42 CFR 438.56 Enrollment and Disenrollment Requirements

DVHA must comply with the enrollment and disenrollment requirements and limitations set forth in 438.56 including; disenrollment requested by DVHA, disenrollment requested by the enrollee, procedures for disenrollment, and timeframes for disenrollment determinations.

DVHA shall ensure that individuals who lose eligibility are disenrolled from the *Global Commitment to Health Waiver*. Loss of eligibility may occur due to:

- Death;
- Movement out of State of Vermont;
- Incarceration;
- No longer meeting the eligibility requirements for medical assistance under the *Global Commitment to Health Waiver*; and
- The enrollee's request to have his/her eligibility terminated and to be disenrolled from the program

DVHA shall compare, on a daily and no less than monthly basis, the active Global Commitment to Health enrollee list with the ESD's Medicaid/VHAP eligibility list to confirm Medicaid/Global Commitment status for all Global Commitment to Health enrollees.

DVHA shall not disenroll any individual except those who have lost eligibility as specified under 2.2.4 of the AHS/DVHA IGA. This prohibition specifically precludes disenrollment on the basis of an adverse change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

> **AHS Monitoring Activities:** AHS will review policies and procedures pertaining to enrollment. Upon request, information on dis-enrollments (by reason code) shall be available to AHS for audit purposes.

DVHA 42 CFR 438.228 Grievance System Requirements

DVHA must have a grievance system that meets the requirements of CFR 438 Subpart F. DVHA and its IGA partners shall adhere to uniform Grievance and Appeals rules and policies. AHS shall be responsible for ensuring grievance and appeals rules, policies and practices comply with the federal statutes and regulations, including provisions applicable to DVHA operations. For purposes of the Grievance and Appeals process, Designated Agencies and Specialized Services Agencies are contracted agents of DVHA and/or its IGA partners Therefore, any decisions these entities make that fall under the definition of "adverse benefit determination" as defined at 42 CFR 438.400 are subject to DVHA appeal process. DVHA must maintain records of grievances and appeals. Grievance is defined as an expression of dissatisfaction about any matter other than an "adverse benefit determination." An appeal is defined as a request for review of an "adverse benefit determination." Adverse Benefit Determination is defined to include:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of DVHA or the Departments to act within the timeframes; or
- Denial of a Medicaid enrollee's request to obtain services outside the network:
  - from any other provider (in terms of training, experience, and specialization) not available within the network
  - from a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
  - Because the only plan or provider available does not provide the service because of moral or religious objections.
  - Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
  - The State determines that other circumstances warrant out-of-network treatment.

AHS Monitoring Activities: The Agency of Human Services (AHS) shall engage in various activities to ensure the following two requirements are met:

- DVHA has in effect a grievance system that meets the requirements of 42 CFR Part 438 Subpart F, and
- DVHA operations related to the processing of grievances and appeals are monitored as specified in 42 CFR 438.66.

First, AHS shall require that the DVHA submit on a quarterly basis a Grievance and Appeal Activity Report. This report shall contain aggregate information regarding the number, type, origin, notification and resolution time, and decision of each activity; a list of all grievances that have not been resolved to the satisfaction of the enrollee; the nature of grievances requiring expedited review and the decisions; and any trends relating to a particular provider or service. If the report reveals "undesirable trends" relating to a particular provider or service, DVHA must conduct an in-depth review, report the findings to AHS, and take corrective action. Second, Grievance and Appeal Activity Reports shall be presented

quarterly to the Agency Quality Assurance and Performance Improvement (QAPI) Committee for identification of patterns or trends that might emerge and to identify areas on which to focus improvement efforts. Finally, AHS or its designee shall annually review a random sample of all grievance and appeal files to ensure that they comply with all applicable AHS standards identified in the Quality Strategy as well as all Federal standards contained in 42 CFR Part 438 Subpart F and 42 CFR 438.210(c). Standards include but are not limited to the following:

- Notice of action
- Resolution and notification
- Expedited resolution of appeals
- Information about the grievance system to providers and subcontractors
- Continuation of benefits
- Effectuation of reversed appeal resolutions

DVHA 42 CFR 438.230 Subcontractual Relationships and Delegation Requirements

A subcontractor means any individual or entity that has a contract with DVHA that relates directly or indirectly to the performance of DVHA operations. A network provider is not a subcontractor by virtue of the DVHA provider agreement. DVHA may subcontract with entities within or outside of State government to provide services under the Demonstration. Contracts with outside entities will follow all necessary State and federal procurement rules and approvals. Inter-Governmental Agreements (IGAs) with other Departments in state government will be used to provide certain covered *Global Commitment to Health Demonstration* services that are relevant to the programs they administer. These other Departments are collectively referred to as "IGA partners" which include the Department for Disabilities, Aging and Independent Living (DAIL), Department of Health (VDH), Agency of Education (AOE), the Department for Children and Families (DCF) and the Department of Mental Health (DMH).

IGA partners are required to adhere to 42 CFR 438 as if they were operating as sub-contractors of a non-risk PIHP. IGA agreements do not diminish the role of state agencies in performing governmental functions as assigned by the AHS or as established under State law. Any activities delegated to a subcontractor or IGA partner will be specified in a written agreement. Written agreements must provide:

- The activities and reporting responsibilities of the contractor or subcontractor;
- That AHS, CMS, the HHS Inspector General, the Comptroller General or their designees have the right to audit, evaluate and inspect any books records, contracts, computer or other electronic systems of the subcontractor or of the sub-contractor's contractor, that pertain to any aspect of services and activities performed or determination of amounts payable under the contract;
- The subcontractor will make available for purposes of audit or inspection its premises, physical facilities, equipment, books, records or contracts related to Medicaid enrollees;
- The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later;
- For revocation of delegation or specify other remedies where AHS or DVHA determines that the subcontractor has not performed satisfactorily.

DVHA will submit sub-contractor ownership and control disclosures to AHS pursuant to 42 CFR 438.602 (c) for all sub-contract agreements with entities that are outside of State government.

No subcontract terminates the responsibility of AHS and DVHA to ensure that all activities as defined in the Medicaid Demonstration Special Terms and Conditions are carried out. In the event of non-compliance, AHS (as the Single State Agency) will determine the appropriate course of action to ensure compliance. DVHA agrees to make available to AHS and CMS all subcontracts between the DVHA and the Departments. DVHA and the Departments shall maintain evaluation tools, reports, improvement plans, and reported service data profiles used in the service plan and utilization review monitoring activity. At the direction of AHS, DVHA may conduct ongoing monitoring of the Departmental subcontractors through the review of required reports and data submissions.

AHS Monitoring Activities: AHS will perform the following activities to ensure compliance with the aforementioned standard:

- Review sample of DVHA contracts or written agreements with entities performing the delegated activities
- Review results of the most recent review of the delegated activity

3. Measurement and Improvement Standards

This section includes a discussion of the standards that the state has established in the DVHA contract for measurement and improvement, as required by 42 C.F.R. Part 438, subpart D (i.e., *practice guidelines*, *quality assessment and performance improvement program*, and *health information systems*). All Performance Improvement Project (PIP) topics, tied to specific goals, are included in the CQS. These standards relate to the overall objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

Regulatory Reference	Brief Description
§ 438.236	**Practice Guidelines**
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees
§438.236(d)	Ensure that the application of the guidelines for utilization management, enrollee education, coverage of services and other others are consistent with such guidelines
§ 438.330	**Quality Assessment and Performance Improvement Program**
§438.330(a)	DVHA must have an ongoing quality assessment and performance improvement program
§438.330(b)(1) & §438.330(d)	DVHA must conduct PIPs and measure and report to the state its performance
§438.330(b)(2) & §438.330(c)	DVHA must measure and report performance measurement data as specified by the state
§438.330(b)(3)	DVHA must have mechanisms to detect both underutilization and overutilization of services
§438.330(b)(4)	DVHA must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs
§438.330(b)(5)	DVHA must have mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee care plan; and participate with the State to prevent, detect and remediate critical incidents that, at a minimum meet §441.302(b) for HCBS programs
§438.330(e)	Annual review by the state of DVHA's process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program
§ 438.242	**Health Information Systems**
§438.242(a)	DVHA must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility
§438.242(b)(1)	Ensure that the claims processing and retrieval systems are able to collect data elements necessary to meet requirements of 1903(r)(1)(F) of the SSA
§438.242(b)(2)	DVHA must collect data on enrollee and provider characteristics and on services furnished to enrollees as specified by the State, including but not limited to race, ethnicity, and primary language spoken of each Medicaid enrollee
§438.242(b)(3)	DVHA must ensure data received is accurate and complete
§438.242(c)	DVHA will collect enrollee encounter data sufficient to identify the provider who delivers any item or service to enrollees on a frequency and level of detailed specified by the State

DVHA 42 CFR 438.236 Practice Guideline Requirements

Practice Guidelines
DVHA and the Departments shall adopt program guidelines that are based on valid clinical evidence, or based on the consensus of health care professionals, consideration of the needs of enrollees, and consultation with health care professionals who participate in the Global Commitment to Health Waiver and other program stakeholders. Program guidelines shall be reviewed and updated periodically as appropriate. DVHA shall disseminate the guidelines to its subcontracted Departments and shall require the Departments to disseminate the guidelines among all their designated providers.

AHS Monitoring Activities: DVHA and the Departments must provide evidence that they have adopted clinical practice guidelines for the treatment of at least two acute or chronic health conditions. AHS shall review the following:

- Practice guidelines
- Provider manuals, enrollee handbook, newsletters, bulletins or other forms of communication for evidence of use of practice guidelines

DVHA 42 CFR 438.330 Quality Assessment and Performance Improvement Program Requirments

DVHA shall maintain a comprehensive Quality Plan for the Global Commitment to Health Waiver that details the plans, tasks, initiatives, and staff responsible for improving quality and meeting the requirements and beneficiary services incorporated under the AHS/DVHA contract. All IGA partners must also develop and maintain an internal Quality Plan. In addition to complying with contractual terms related to specific CQI activities, processes and reporting, DVHA must have procedures that:

- Assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs;
- Detect the over-utilization and under-utilization of health care services;
- Regularly monitor and evaluate compliance with managed care standards; ,
- Comply with any national performance measures and levels that may be identified and developed by the Center for Medicare and Medicaid Services (CMS) in consultation with AHS and other relevant stakeholders; and
- Assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including:
    - Assessment of care between care settings;
    - A comparison of services and supports received with those set forth in the enrollee's treatment/service plan; and
    - Participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§ 441.302 and 441.730(a) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per § 441.302(h)

The Quality Management Plan shall conform to all applicable Federal and State regulations. The Quality Management Plan shall be available to AHS upon request.

DVHA and the Departments are required to report Performance Measures including results from Consumer Satisfaction Feedback Activities to AHS to assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs. Performance Measures will be required in the following focus areas:

- Childhood and Adolescent Immunization;
- Chronic Conditions – Asthma and Diabetes;
- Prenatal Care;
- Children's Health – Well-Child Visits;
- Oral Health – Annual Dental Visits;
- Behavioral Health;
- Consumer Satisfaction; and
- For LTSS enrollees: quality of life; rebalancing of community care and institution care; and community integration.

DVHA will report Performance Measurement data to AHS on a quarterly basis. DVHA is required to track and trend this data to watch for any patterns. A corrective action report will be required after 3 quarters of a negative trend. DVHA might include plans for a Performance Improvement Projects when the agreed upon indicators is below the performance rate previously defined. Possible Performance measures could include:

- HEDIS® clinical measure
- HEDIS®-like clinical measure
- CAHPS composite, rating result or question
- Non-CAHPS composite, rating result or question in an area of service identified as relevant to the MCE's enrollees.

DVHA must also conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services that are expected to have a favorable effect on health outcomes and member satisfaction. The performance improvement projects should focus on clinical and non-clinical areas, and involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvements in the access to and quality of care;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting of the status and results of each project, no less than annually, to AHS as requested in a timely manner.

Each year DVHA must select one focus area in which to conduct a quality improvement project. These projects may take several years to complete but must demonstrate sustained improvement as required in the CMS protocol. Proposed projects will be submitted to AHS for review and approval assuring the project meets the following criteria:

- Evaluates the quality (i.e., effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness) of programs/services and care
- Has a favorable effect on the structure, process, or outcome of programs/services and/or care
- Uses indicators of quality that are objective performance measures (i.e., use of measures and metrics),

- Increases or sustains the improvements obtained.

The CMS or AHS may specify performance measures and topics for performance improvement projects.

AHS Monitoring Activities: AHS will annually review the DVHA Quality Plan, including practitioner availability and accessibility, clinical practice guidelines, continuity and coordination of care, clinical and non-clinical performance measures, and performance improvement activities. Review of the quality program includes use of preventive health guidelines and disease management programs, care coordination or case management programs to enrollees and practitioners. Other standards reviewed include: utilization management, information systems, medical record documentation standards and confidentiality policies and procedures.

AHS will monitor results of performance measures (including feedback from enrollees) and other methodologies to monitor services provided to Vermont Medicaid members annually. In addition to consumer satisfaction surveys, AHS will also monitor member perceptions of accessibility and adequacy of services through the use of anecdotal information, grievance and appeals data, and enrollment information. Audits of the performance measures are followed by corrective action plans when appropriate. DVHA and its sub-contracts are also required to report the status and results of each performance improvement project in an annual report and upon request of AHS. In addition to the above, AHS will perform the following activities:

- Review data gathered as a result of compliance monitoring activities
- Conduct compliance monitoring of QAPI Standards
- Review data for evidence that claims are evaluated to assess the degree of over-and under-utilization

DVHA 42 CFR 438.242 Health Information Systems Requirements

In accordance with 42 CFR 438.242, DVHA shall maintain a management information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The system must collect data on enrollee and provider characteristics including but not limited to race, ethnicity, and primary language spoken of each Medicaid enrollee. DVHA management information system must have the capabilities to collect, maintain, and report encounter data in accordance with the Global Commitment to Health Waiver's Terms and Conditions. All collected data must be available to AHS and the CMS upon request.

DVHA must also maintain claims history data for all Global Commitment to Health Waiver enrollees through contractual arrangements with its Fiscal Agent. IGA partners shall submit encounter reports for all services rendered to Global Commitment to Health Waiver enrollees, when service-specific claims for such services are not processed through the MMIS. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid Waiver Demonstration. DVHA must make such claims and encounter data available to AHS and CMS upon request.

Encounter data submitted to DVHA and IGA partners will be edited by DVHA and IGA partners for accuracy, timeliness, correctness, and completeness. Any encounter data failing edits will be deleted. Any encounter data denied will be returned to the provider for review and possible resubmission. Encounter data must represent services provided to Global Commitment to Health Waiver enrollees only and be collected and maintained in a manner sufficient to identify the provider who delivers any item(s) or service(s) to enrollees. DVHA must have

a process to ensure that services were actually provided. In addition to the automated process described above, DVHA will at least biennially perform medical/case record reviews for the purposes of comparing submitted claims and encounter data to the medical record to assess correctness, completeness and to review for omissions in encounters or claims.

While there is currently an information system that supports initial and ongoing operation and review of the Quality Strategy, AHS in collaboration with DVHA and its IGA partners is currently developing a data ware house that will be able to provide encounter (i.e., aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities). This evolving Health Information Technology will impact the future monitoring of QAPI activities.

AHS Monitoring Activities: AHS shall have access to the claims and encounter data as reported by DVHA or its IGA partner. AHS will monitor DVHA encounter and claims data procedures in order to ensure compliance with this standard. Monitoring includes the following activities:

- Review procedures used by DVHA to ensure the reliability of the data obtained from the providers and contained in it MIS
- Review reports produced by the MIS to support utilization management, grievance processes, enrollment services, and its QAPI program
- Review provider contracts to determine the extent to which expectations for data collection and reporting are outlined

4.HCBS Standards

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home and community-based settings (HCBS), with additional guidance and information posted on March 18, 2014. The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving services and supports under 1915(c), 1915(k), and 1915(i) Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting.

Based on considerable stakeholder interest, Vermont is taking this opportunity to assess programs/settings for GC Demonstration populations that are designated by the State as persons with Special Health Care needs under 42 CFR 438. In addition to Choices for Care participants – the following Special Health Need populations will also be considered:

- Developmental Services (DS)
- Traumatic Brain Injury (TBI)
- Children with a Severe Emotional Disturbance (SED)
- Community Rehabilitation and Treatment (CRT)

All home and community-based settings associated with the aforementioned populations must have all of the following qualities, based on the needs of the individual as indicated in their person-centered service plan:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. *42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)*

- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)*

- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. *42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)*

- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. *42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)*

- Facilitates individual choice regarding services and supports, and who provides them. *42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)*

Table 9: HCBS Regulations – Examples of Acceptable Practice.

REGULATORY REQUIREMENT	EXAMPLES OF ACCEPTABLE PRACTICE
Opportunities to seek employment and work in competitive integrated settings	Individual works in an integrated setting or, if the individual would like to work, there is activity that ensures the option is pursued.
Engage in community life	Individual regularly accesses community as chooses (shops, attends religious services, schedules appointments, lunch with family and friends) Individual has access to public transportation, accessible transportation for appointments and shopping; training to use public transportation. Where public transportation is limited, other resources are provided. Individual participates regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual
Control personal resources	Individual has checking or savings account or other means to control own funds; access to own funds.
Receive services in the community	Individual can choose from whom they receive services and supports.
Privacy	Individual can make private telephone calls/text/email at the individual's preference and convenience. Health information is kept private. Assistance provided in private, as appropriate, when needed.
Dignity and respect	Individual is assisted with grooming as desired; assisted with dressing in their own clothes appropriate to the time of day, weather and preferences. Staff communicates with individuals in dignified manner. Informal (written and oral) communication conducted in a language that the individual understands.
Freedom from coercion	Individuals are free from coercion: e.g., able to file complaints, discuss concerns; able to make personal decisions such as hairstyle and hair color
Freedom from restraint	Individual has unrestricted access in the setting: no barriers to exit and entrance; physical accessibility.
Initiative, autonomy and independence	Individual is free to come and go at will (no curfew or other requirement for a scheduled return to the setting) The setting is an environment that supports individual comfort, independence and preferences (*e.g.*, kitchen with cooking facilities, dining area, laundry, and comfortable seating in shared areas).

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REGULATORY REQUIREMENT	EXAMPLES OF ACCEPTABLE PRACTICE
Daily activities	Individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan. Participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services. The individual chooses when and what to eat. The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.
Physical environment	The individual has his/her own bedroom or shares a room with a roommate of choice.
With whom to interact	The individual chooses with whom to eat or to eat alone. Visitors are not restricted.
Choice of services	Staff ask individual about needs and preferences. Individuals are aware of how to make a service request. Requests for services and supports are accommodated as opposed to ignored or denied. Choice is facilitated in a manner that leaves the individual feeling empowered to make decisions.
Choice of providers	The individual chooses from whom they receive services and supports. Individual knows of other providers who render the services s/he receives. Individual knows how and to whom to make a request for a new provider.

Adapted from CMS, *Exploratory Questions to Assist States in Assessment of Residential Settings* accessible at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Exploratory-questions-re-settings-characteristics.pdf.

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Provider-owned or controlled residential settings must also comply with some additional requirements. Standards that apply to provider-owned or controlled residential settings include the following:

- Responsibilities and rights of tenant, Legally enforceable agreement
- Privacy in sleeping or living unit
- Lockable doors, staff have keys only as needed
- Freedom to furnish and decorate
- Choice of roommates for shared rooms
- Control own schedule and activities and access to food at any time
- Able to have visitors at any time
- Physically accessible

Under Certain Conditions a Residential Provider can Modify Some of These Additional Requirements. Additional requirements may be changed only when a member's Person Centered Plan describes:

(*1*) Identify a specific and individualized assessed need.
(*2*) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(*3*) Document less intrusive methods of meeting the need that have been tried but did not work.
(*4*) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(*5*) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(*6*) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(*7*) Include the informed consent of the individual.
(*8*) Include an assurance that interventions and supports will cause no harm to the individual.

*The requirement that a setting is physically accessible may not be modified.

MCE Monitoring Activities

The MCE must determine whether services in these settings meet the community standards set forth in the rules. Initial and ongoing compliance with standards will include, but not be limited, to the following methods: licensing reviews, provider qualification reviews, site visits, survey of individuals in receipt of HCBS, provider self-assessment, or a sample of settings. If necessary, CMS will allow Vermont up to four years to phase in these changes. All such services will be in compliance with CMS requirements before March 2019.

IV. IMPROVEMENT & INTERVENTIONS

This section describes how the state will attempt to improve the quality of care delivered by the MCE through interventions including, but not limited to the following: Cross-state agency collaborative; Grants; and Disease management programs.

Improvement

AHS will assess whether or not the objectives identified in the Introduction have been met by comparing results of performance measures over time. Based on the results of the assessment activities, AHS will attempt to improve the quality of care provided by the MCE. Examples of interventions that might be applied include but are not limited to the following:

- Cross-agency collaborative/initiatives
- Performance improvement projects
- Changes in benefits for program participants
- Information system or electronic health record initiatives
- Implementing optional EQRO activities

In the CQS, AHS will describe the process it intends to follow to embark on quality improvement. As results from the assessment activities are produced, AHS will be able to more clearly define steps to quality improvement. Interventions for improvement of quality activities are varied and based on the ongoing review and analyses of results from each monitoring activity by the State and EQRO. As results from assessment activities are produced, it is likely that AHS will be able to further and more clearly define interventions for quality improvement as well as progress towards objectives. The State's EQRO report will include an assessment of MCE's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, recommendations for improving the quality of health care services furnished by each MCE, and an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This information will be used to inform any needed quality improvement activities, sanctions, or other program changes. Additionally, the EQRO report will be used to inform the State of any needed oversight or regulatory support to improve managed care health care delivery.

1. Intermediate Sanctions

The premise behind the CQS is one of continuous quality improvement. AHS strongly believes in working with the MCE in a proactive manner to improve the quality of care received by VT Medicaid recipients. However, should the need arise; part of AHS's quality management process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. The sanctions of MCE plan meet the federal requirements of 42 CFR 438 Subpart I, as well as State requirements for sanctions and termination. AHS will have the right to impose penalties and sanctions, arrange for temporary management, as specified below, or immediately terminate MCE contract under conditions specified below.

2. Health Information Technology

This section details how the state's information system supports initial and ongoing operation and review of the state's quality strategy. In addition, it describes any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.

Electronic Health Record Incentive Program (EHRIP)

The Vermont EHRIP is an integral part of the HIE/HIT program, establishing electronic health records as a source of clinical data for transmission to the HIE. It began in 2011 and to date, has awarded over $47 million dollars in incentive payments to approximately one thousand eligible providers and hospitals enrolled in the program. Vermont's EHRIP program is designed to support providers' adoption of certified electronic health record technology to improve the quality, safety and efficiency of patient health care.

The Electronic Health Record Incentive Program (EHRIP) is designed to support providers during the period of transition in health information technology. The vision is that electronic health record use will improve the quality, efficacy, and efficiency of patient health care.

Health Information Technology (HIT) and Health Information Exchange (HIE) Activities

The HIE/HIT program in Vermont is organizationally housed in the Department of Vermont Health Access (DVHA); the Vermont Medicaid Enterprise. The Vermont Health Information Exchange (VHIE) is a Medicity platform with enhanced local capabilities operated exclusively (by statute) by Vermont Information Technology Leaders (VITL). Working closely with the VHCIP program and partnering with other departments within the Vermont Agency of Human Services, the HIE/HIT program provides facilitation, HITECH funding and technical support for meaningful use as well as health data and infrastructure needs across the health care landscape in Vermont. Through health data accessibility, the VHIE aims to enhance care coordination, health care data analytics, and population health management.

The Health Data Exchange Network takes responsibility for the management, exchange and access to clinical and human services data throughout the clinical provider community, the Vermont Agency of Human Services and their affiliated entities. The program vision is to ensure the wellbeing of all Vermonters by ensuring that health and human services data is available at the right time, in the right place, and in the right way to support continuous improvements in individual health, health care outcomes, and health care cost.

Vermont Health & Human Services Enterprise Platform (HSEP)

The Human Services Enterprise Platform (HSEP) is a shared suite of modern technology tools positioned to satisfy a significant portion of AHS' software needs including transactions, analysis, and infrastructure. Today these needs are supported by over 200 different, detached, disconnected software packages. Leveraging one system, over many, represents material savings for the State, and allows for rapid response to ever-changing regulatory, policy, and programmatic demands. Components of note in the HSEP include a rules engine, an Electronic Service Bus (ESB), and an anticipated Master Data Management (MDM) solution, including enterprise Master Person Index

(eMPI), a Provider Directory, and a consent management solution. This architecture was deployed first to establish the Health Insurance Exchange, MAGI Medicaid, and Dr. Dynasaur. The Vermont Health & Human Services Enterprise Platform unifies four Vermont health care reform programs with the vision of providing infrastructure, services, and functional components that each program can share.

The Health and Human Services Enterprise (HSE)

The Health and Human Services Enterprise (HSE) is a portfolio of programs (Vermont Health Connect, Integrated Eligibility, Medicaid Management Information System, HIE/HIT) that rely upon a Services Oriented Architecture (SOA). The HSE is a multi-year, multi-phased portfolio of programs whose goals are, in furtherance of the mission of the Agency of Human Services (AHS), to reshape and enhance internal business processes, improve public/private sector partnerships, optimize utilization of information, and modernize the IT environment within which AHS delivers benefits, care and services to beneficiaries in the State of Vermont. The HSE was expressly established by the Secretary of AHS to realize the "Agency of One" vision through a focus on integrating services, improving systems and the sharing of applicable data in a timely and effective manner (while comporting with relevant privacy requirements) to ensure:

- Vermonters receive the services critical to their success and can identify additional supports that will help them prosper;
- Vermonters will benefit from cross-departmental referrals and awareness – that there exists "no wrong door" for Vermonters seeking access to care and benefits;
- Policy and Public Health efforts have necessary data for program analysis and program service coordination.

The Agency of Human Services' (AHS) Health & Human Services Enterprise (HSE) is Vermont's approach to transform legacy systems into an environment of coordinated and integrated service delivery. The Health & Human Services Enterprise Platform (HSEP) is fundamental to and supports Vermont's concept of the HSE which encompasses the Vermont Health Connect (VHC) insurance exchange, Integrated Eligibility & Enrollment (IE&E), Medicaid Management Information System (MMIS), and HIT/HIE.

Vermont Health Connect

Vermont launched a federally required health benefits exchange, Vermont Health Connect (VHC), on October 1, 2013. VHC allows individuals and small businesses to compare and purchase qualified private health insurance plans, access federal and state tax credits, determine eligibility, and enroll individuals in public health insurance plans. Vermont Health Connect (VHC), currently uses the HSEP's basic Health Insurance Exchange and Eligibility & Enrollment services and capabilities for access to Qualified Health Plans, MAGI Medicaid and Dr. Dynosaur.

Integrated Eligibility and Enrollment

Integrated Eligibility and Enrollment (IE&E) is a technical solution that is being developed to determine Vermonters' eligibility and to enroll them in a multitude of assistance services sponsored by the Agency of Human Services, rather than have disparate processes for these services. IE&E will leverage already developed elements in Vermont Health Connect. It will add capabilities to the HSEP allowing for automation and standardization of the health & human services case management and

program administration systems (screening, application, eligibility determination and enrollment). This represents the integration of the Agency's remaining health programs and economic services into one system.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) Program is a collective initiative under the Health & Human Services Enterprise. The new MMIS Program is being developed to align with new Federal and State regulations stemming from the Federal Affordable Care Act and Vermont Act 48 of 2011, as well as be compliant with the CMS Seven Standards and Conditions. The MMIS Program is a claims processing system that will streamline billing, payment, and other Medicaid operational components.

There are two key projects under the MMIS umbrella that are currently underway.

i. The **Pharmacy Benefit Management (PBM)** program represents clinical, operational, and business services that allow Vermont to meet the challenge of increasing pharmaceutical costs for consumers with a real solution. Vermont's PBM program is aimed at both reducing and controlling costs of drugs and providing the State with high quality, local pharmaceutical expertise. In FY2016, the PBM generated $15.3 million in savings thanks to improved operational efficiency.

ii. **Care Management** is a set of activities intended to improve clinical patient care and reduce the need for services by helping patients and caregivers more effectively manage health conditions and issues impacting health and well-being. **The Enterprise Care Management System** supports not only AHS care management staff but also hundreds of Vermont provider organizations engaged in direct care services. The Enterprise Care Management system offers some of the highest levels of sophistication in forecasting & analytics, and vastly improves Vermont's ability to utilize data to improve population-wide outcomes. The system will unite and integrate the Agency's related care management programs in a way that was never possible before.

These combined responsibilities provide Vermont with a powerful engine for delivery system change, as well as creating a focused perspective for managing the comprehensive IT and other systems changes being led by DVHA in support of that system change. Many of these delivery system changes affect the Agency of Human Services along with many private and community organizations. In support of Vermont's aggressive payment and delivery reform goals, the State has identified the following IT initiatives:

- Implement technological solutions, including data warehouses and point-of-care tools, in support of Vermont's All-Payer Model Agreement and Medicaid 1115 Global Commitment to Health waiver;
- Build out of the statewide HIE network to provide connectivity for clinical and financial data transfer;
- Implement core components of SOA infrastructure to support the Agency of Human Services and its partners;
- Re-procure the Medicaid Management Information System (MMIS) in a modular approach as a more comprehensive and integrated enterprise solution;
- Provide statewide outreach to and support for EHR adoption, implementation, upgrade and meaningful use;
- Continue technical support for the statewide expansion of the Blueprint for Health patient-centered

medical home, that includes the build out of a statewide clinical data registry, decision support, and clinical messaging system integrated with HIE and EHR systems to support both Meaningful Use and implementation and evaluation;

- Develop and implement technology in support of population health including Vermont's Immunization Registry, Prescription Management System, and other public health reporting functions through the HIE;
- Develop and implement an upgrade to AHS' eligibility and enrollment systems, Integrated Eligibility (IE), which will include integration with the state Health Insurance Exchange; and
- Expand or replace AHS' CSME (Central Source for Measurement and Evaluation), which is the Agency- wide data warehouse to support Medicaid and other Agency program operations, reporting, evaluation, and planning.

V. DELIVERY SYSTEM REFORMS

Health care in Vermont – as well as in the country as a whole – is in the midst of a major transformation. In Vermont, health care reform efforts touch virtually all sectors of health and health services. The Vermont Medicaid program has historically paid for services for Medicaid beneficiaries on a FFS basis. Increasingly, Vermont's Medicaid program has been expanding its use of service delivery and payment systems, as an alternative to traditional FFS. In addition, the current 1115 Medicaid Waiver, Global Commitment to Health, promotes delivery system and payment reform by allowing Vermont Medicaid to enter into ACO arrangements that align in design with that of other health care payers in support of the Vermont All-Payer ACO Model. Tables 1 and 2 below identify Vermont health reform efforts sponsored by the Vermont Medicaid Program and the various delivery system and payment reform models they support.

Table 1: Vermont Health Reform Effort by Delivery System Model Supported

VT Health Reform EFFORT	Delivery System Model				
	Managed Care Organization (MCO)	Managed Long Term Services and Supports (MLTSS)	Patient Centered Medical Home (PCMH)	Health Homes	Accountable Care Organizations (ACO)
Oral Health	X				
Blueprint					
Community Health Team	X				
Women's Health Initiative	X				
NCQA			X		
Global Commitment to Health Waiver	X	X			
DVHA Next Generation					X
Integrating Family Services	X				
Children's Integrated Services	X				

Table 2: Vermont Health Reform Effort by Payment Reform Model Supported

VT Health Reform EFFORT	Payment Reform Model							
	Capitation	Enhanced Care Coordination Care Management Fee	Pay-for-Performance (P4P)	Shared-Savings Arrangements	Shared-Risk Arrangements	Episode of Care Payment (EOC)	Global or Bundle Payment	Delivery System Reform Investments
Dental Supplemental Payment Program		X						
Blueprint		X	X					
Global Commitment to Health Waiver	X			X				X
DVHA Next Generation ACO					X			
Integrating Family Services							X	
Children's Integrated Services		X						

Dental Supplemental Payment Program

The Dental Supplemental Payment Program was created to recognize and reward dentists serving high volumes of Medicaid beneficiaries. The supplemental payment program methodology was developed by Vermont Medicaid in conjunction with the Vermont State Dental Society, in accordance with Act 215, Section 108. The supplemental payment program methodology was reviewed and unanimously approved by the Health Access Oversight Committee at their September 19, 2006 meeting. The SFY '08 appropriation provided for the funds for the supplemental payment. This increase has been incorporated into the base Medicaid appropriation so supplemental payments will be made every six months to the dental practices that meet the supplemental payment program criteria for serving Vermont Medicaid beneficiaries. Dental practices that receive cost-based reimbursement (like Federally Qualified Health Centers) are ineligible for the program.

Blueprint

The Blueprint for Health is a state-led, multi-payer program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness. As such, the Blueprint employs several different approaches to incentivizing delivery system reform and increased quality and performance through payment reform.

<u>Advanced Primary Care Practice/Patient Centered Medical Home</u>

The foundation of the Blueprint model is a Multi-payer Advanced Primary Care Practice (MAPCP) program. Participation is optional for providers, but mandatory for Vermont's commercial payers (with the exception of

self-insured plans) and Medicaid. Current participating payers in the Blueprint for Health include Medicaid, Medicare, Blue Cross Blue Shield of Vermont, MPV and CIGNA. The Blueprint MAPCP pay for performance model uses a Per-Member-Per-Month approach (PMPM) to incentivize primary care practices to qualify and maintain accreditation as a Patient Centered Medical Home (PCMH) and to participate in local community collaboratives oriented towards improving population health and local care coordination activities for their region.

The Blueprint advances the AHS Comprehensive Quality Strategy by addressing Access, Quality and Cost. Additionally, Blueprint for Health is featured in the Global Commitment to Health Section 1115 Evaluation Plan in support of the following three hypotheses:

- Improved access to primary care will result in positive health outcomes;
- Enhanced care coordination will promote timely access to needed care; and
- Improved access to primary care will result in overall lower cost for the healthcare delivery system.

Community Health Teams

The Community Health Team (CHT) is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations. The goal is to provide citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services. The CHT is flexible in terms of staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHT services are available to all patients with no eligibility requirements, prior authorizations, referrals or co-pays.

Key stakeholders in each health service area (HSA) must agree upon and identify at least one administrative entity accountable for leading implementation and ongoing operations of the MAPCP model in their HSA. Lead administrative entities receive multi-insurer payments, including Medicare and Medicaid, to support hiring of local Community Health Teams (CHTs).

The number of core CHT members hired in each geographic service area is scaled up or down, depending on the size of the population served by participating Primary Care Practices.

The Blueprint advances the AHS Comprehensive Quality Strategy by addressing Access, Quality and Cost. Additionally, Blueprint for Health is featured in the Global Commitment to Health Section 1115 Evaluation Plan in support of the following three hypotheses:

- Improved access to primary care will result in positive health outcomes;
- Enhanced care coordination will promote timely access to needed care; and
- Improved access to primary care will result in overall lower cost for the healthcare delivery system.

Women's Health Initiative

The Blueprint Women's Health Initiative (WHI) is aimed at improving the health of women and reducing the rate of unintended pregnancies. The Initiative extends participation in the Blueprint to women's health care providers, including obstetrics, gynecology, midwifery, and family planning providers. Year one the initiative is Medicaid only pilot. Other payors are invited but not required to participate. Participating practices affiliate with an established Blueprint Community Health Team (CHT) and receive performance incentives to support effective family planning and preventive care for women.

Through the WHI, women's health providers will provide enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC) for women who choose LARC as their preferred method of birth control. New staff, training, and payments will support effective screenings, brief in-office intervention and referrals to services for mental health, substance abuse, trauma, partner violence, food insecurity, and housing instability.

Women's Health Initiative payments begin January 1, 2017 and will be evaluated annually as part of the Blueprint for Health overall performance monitoring plan. The quality and utilization performance component is expected to begin in year two (2018). At that time the base PMPM will be adjusted and will include additional bonus up to $ 0.50 PPPM. The outcome measures driving the performance component of the PMPM payment in the second and subsequent years will be determined in 2017 and will include a combination of measures at the community- and practice-levels. The WHI aligns with the AHS Comprehensive Quality Strategy (CQS) in the areas of Access and Quality.

Global Commitment to Health Wavier

The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the Global Commitment to Health 1115 research and demonstration waiver. While not a formal Managed Care Organization, the Department of Vermont Health Access (DVHA) operates the Vermont Medicaid program using a managed care-like model in accordance with federal Medicaid managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment (GC) enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the GC Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Overall implementation of the waiver is guided by the goals, measures and monitoring activities outlined in the AHS Comprehensive Quality Strategy (CQS).

DVHA Next Generation Accountable Care Organization (ACO)

The Agency of Human Services has implemented the Vermont Medicaid Next Generation Model Accountable Care Organization (ACO) Program. This program is a one-year program with four optional one-year extensions. The program is an agreement between Medicaid and provider organizations (under an umbrella ACO) that aims to hold providers accountable for patient quality of care and costs. By providing a prospective, all-inclusive, population-based capitation payment to the ACO for a set of defined health services, the program seeks to improve the efficiency and quality of care delivery to the program's assigned Medicaid beneficiaries, and provide the opportunity for an ACO to perform their own utilization and care management activities.

The Medicaid Next Generation Model ACO Program is an evolution of Vermont's current Medicaid ACO program, the Vermont Medicaid Shared Savings Program (VMSSP), which began in 2014 and just completed its third and final performance year in 2016. Because the VMSSP offered an upside-only risk arrangement (in which ACOs are not responsible for shared losses), the Next Generation Model ACO program's shared financial risk requirement goes further than the VMSSP to hold providers accountable for patient outcomes and costs. It should be noted that although the Vermont Next Generation Model ACO is structured similarly to the Medicare Next Generation ACO Model, it has been modified to address the needs of the Medicaid population in Vermont.

Integrating Family Services (IFS)

The goal of the Integrating Family Services (IFS) delivery and payment reform is to ensure that beneficiaries receive appropriate and integrated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services commensurate with their age, developmental needs and family circumstances without regard to rate variations, prior approvals and limitations typical of traditional fee-for-service claiming.

Prior to the pilot, specialized Medicaid services were overseen by six departments and multiple divisions of the Agency of Human Services and were subject to fragmented program criteria and provider service delivery requirements. Oftentimes children and families, served by the same provider, required services that cut across various Medicaid programs with duplicative or conflicting provider expectations. Along these lines, when a child's or family's needs exceeded a given program's focus, they could sit on waiting lists or be referred to multiple providers for similar services. Early intervention was limited and prevention difficult.

As part of the pilot, program rules and provider expectations were reviewed and revised across eleven different children's service areas to support early intervention, comprehensive treatment and integrated care. Program rules were streamlined into one single provider manual (Linked Here) to guide IFS pilot provider operations.

Currently, the IFS initiative is a pilot in two regions of the State. A total of three providers (one early childhood and two specialized mental health providers) are involved. One provider is "all-inclusive" in that a single agency provides all the services and programs identified in the initiative, for pregnant women and children 0-21 years old, in their region. However, expansion in other regions is expected to include formal collaboration across multiple providers in any given community.

To be eligible for the pilot, providers must agree to work as part of an integrated network involving multiple providers and community settings in their catchment area. Local provider agreements must be formal and submitted to the State prior to participation in the reform model. Local agreements address: provider roles and responsibilities; unified clinical triage processes; joint waiting list review; HIPAA-compliant information sharing; and streamlined reporting to the State. While IFS providers are obligated to adhere to the streamlined yet rigorous program requirements, the alternative reimbursement model affords greater flexibility to deploy service strategies to best meet the needs of Medicaid-eligible children and families.

The goals of the project are: a) to improve the delivery of services and ultimately the health and well-being of pregnant/postpartum women, infants, children and young adults and b) advance maternal and child health and safety, family stability, and optimal healthy development through the transition to adulthood.

The IFS project advances the AHS Comprehensive Quality Strategy (CQS) goals in the areas of access, quality and in offering stable, in-home and community alternatives to institutional care. The IFS Performance monitoring and measurement plan (Linked Here) includes 22 measures, ranging from process measures e.g., hours of direct service and treatment planning timelines to outcomes e.g., improvement in functioning, stable in-home and community living and family satisfaction/experience of care.

Children's Integrated Services (CIS)

Children's Integrated Services (CIS) provides health promotion, prevention, and early intervention services to pregnant and postpartum women, infants and children birth to age six. In addition to streamlining program requirements and administration for early childhood services, CIS also combined Medicaid funding for covered services to create a single case rate within each region.

Under the recently approved Special Terms and Conditions for extension of the Global Commitment Demonstration, Vermont will be required to obtain federal approval for certain Medicaid reimbursement methodologies, including CIS. Vermont has elected to revise the case rate methodology to reflect more current experience and to ensure that the methodology is:

- Reasonable and appropriate to ensure access to high-quality services;
- Based on utilization of Medicaid-covered services; and
- Appropriate to advance the State's Quality Strategy.

VI. CONCLUSIONS & OPPORTUNITIES

Achievements since the initial quality strategy was developed include:

- Implementation and engagement of the External Quality Review Organization;
- Selection and reporting of HEDIS, and select child core set and adult core set measures
- Selection of performance goals and implementation of a performance accountability framework;
- Maturation of the PIPs with technical assistance from the EQRO;

As described in Section III. Improvement, the MCE performance regarding PIPs and many performance measures has improved over time. Health Services Advisory Group, Inc. has noted that the Agency has significantly enhanced the overall monitoring of compliance review activities. The Agency will continue to work with its partners to move the MCEs to higher quality in clinical and administrative practices.

Global Commitment to Health Evaluation Highlights

1. Global Commitment's ability to increase Medicaid beneficiary access to primary care

Global Commitment has succeeded at increasing access to care for Vermont Medicaid beneficiaries over the years of the waiver as measured in the following areas:

- *Average Enrollment:* Between 2008 and 2014, average annual enrollment grew by approximately 5, 000 individuals; for an overall increase of 32.3%.

- *Number of Uninsured:* The uninsured rate in Vermont decreased from 7.6% in 2009 to 6.8% in 2012, well below the national rate of 15.7% in 2011 (most recent U.S. Census data available).

- *HEDIS Measures:* Global Commitment improved in standing relative to HEDIS access to care measures and as related to scores achieved by accredited Medicaid HMO's as reported in the NCQA 2014 report: State of Health Care Quality.

    - Global Commitment was significantly higher than the accredited Medicaid HMO average (14.4%) for Well Child Visits in the First 15 months of Life.
    - Global Commitment continues to achieve high performance for Child and Adolescent access to primary care physician (PCP) with scores ranging from 91.7% to 98.3% across the childhood years. All score were above the associated Medicaid HMO averages
    - Global Commitment also achieves high scores related to Adult Access to Preventive and Ambulatory Care, 84.1% to 93% across the adult years.

- *Beneficiary Satisfaction*: According to the CAHPS 2014 Medicaid Adult Survey, 86% of respondents answered that they "always/usually" got the care they needed and 83% reported "always/usually" receiving that needed care quickly. Overall, CAHPS survey results for these measures have remained steady over the past few years. A further break down of that composite data shows that 81% of respondents answered that they received an appointment for a check-up or routine care as soon as they needed. Similarly, 81% of those surveyed said they "always/usually" got an appointment to see a specialist as soon as they needed.

2. Extent to which Global Commitment has enhanced the quality of care for Medicaid beneficiaries

Global Commitment has succeeded at enhancing the quality of care for Vermont Medicaid beneficiaries as measured in the following areas:

- The Vermont Chronic Care Initiative has made improvements in health outcomes for Vermont's highest risk Medicaid beneficiaries. Inpatient hospital utilization among the Top 5% was reduced from Program Year 5 (PY5) to Program Year 6 (PY6) by 37%, declining from 476 visits per 1,000 members in SFY 2012 to 301 visits per 1,000 members in 2013.
- Readmission rates for Vermont Chronic Care Initiative members in the Top 5% dropped from PY5 to PY6 by 34%, from 77 readmissions per 1,000 members in SFY 2012 to 51 per 1,000 members in SFY 2013.

- Emergency room utilization for Vermont Chronic Care Initiative members was 17% lower among the Top 5% from PY5 to PY6, decreasing from 1,461 visits per 1,000 members in SFY 2012 to 1,215 visits per 1,000 members in 2013.

- Vermont's Medicaid program had above-average performance (greater than the national HEDIS 75th percentile) in 2014 for the following HEDIS measures that also relate to quality of care:
  - ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
  - ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
  - ✓ Use of Appropriate Medications for People with Asthma (total);
  - ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits; Children's and
  - ✓ Children and Adolescents' Access to Primary Care Practitioners (all indicators);
  - ✓ Adults' Access to Preventive/Ambulatory Health Services; and
  - ✓ Annual Dental Visits measure, which involve distinct provider specialties.

3. Global Commitment's ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver

Global Commitment has contained spending relative to the absence of the Demonstration over the years of the waiver. The cost-effectiveness of the Demonstration can be summarized as follows:

Choices for Care Evaluation Highlights

1. Choices for Care's ability to increase Medicaid beneficiary access to primary care

Choices for Care has succeeded at increasing access to care for Vermont Medicaid beneficiaries over the years of the waiver as measured in the following areas:

- CFC increased in its ability to serve participants in the community. Data demonstrated that more participants are being served in HCBS settings: 49% of CFC participants are served in nursing facilities and 51% are served in HCBS settings.
- In addition to increasing percentages of Highest and High Needs Group participants living in home and community settings, there were no waiting lists for High Needs Group participants.
- There were decreases in the number of applicants waiting for eligibility and financial determination.
- CFC participants expressed satisfaction regarding access to the types and amount of supports they need and want.

2. Extent to which Choices for Care has enhanced the quality of care for Medicaid beneficiaries

Choices for Care has succeeded at enhancing the quality of care for Vermont Medicaid beneficiaries as measured in the following areas:

- CFC maintained positive gains in terms of quality, satisfaction, staff courtesy, and choice.
- CFC maintained good ratings of sense of choice and control. Ratings continued to be high for someone to listen, someone to count on in an emergency and safety.
- There were improved ratings for social life satisfaction and achievement of personal goals.
- Self-rated health remained steady.

3. Choices for Care's ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver

Choices for Care has contained spending relative to the absence of the Demonstration over the years of the waiver. The cost-effectiveness of the Demonstration can be summarized as follows:

- CFC remained budget neutral. The Long Term Care portion of the Choices for Care budget was under budget by $7,733,594 thru the end of SFY13.

Since 2007, the Vermont Agency of Human Services (AHS) has contracted with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to review the performance of DVHA in the three CMS required activities (i.e., Compliance with Medicaid Managed Care Regulations, Validation of Performance Improvement Projects, and Validation of Performance Measures), and to prepare the EQR annual technical report which consolidates the results from the activities it conducted. Over the past five years, HSAG reports observing tremendous growth, maturity, and substantively improved performance results across all three activities. Vermont's Medicaid Managed Care Model has achieved the following scores relative to the three mandatory areas of EQR:

- Average Overall Percentage of Compliance Score of 93.8%;
- Average Performance Improvement Validation scores for Evaluation Elements Met of 98.4%, Critical Elements Met of 100%, and an Overall Validation Status of Met for each year - indicating high confidence in the reported results; and
- Performance Measures Validation finding of 100% Fully Compliant and a determination that the measures were valid and accurate for reporting for each year.

In addition, with each successive EQRO contract year, HSAG has found that DVHA has increasingly followed up on HSAG's prior year recommendations and has initiated numerous additional improvement initiatives. For example, they found that Vermont's Medicaid Managed Care Model regularly conducts self-assessments and, as applicable, makes changes to its internal organizational structure and key positions to more effectively align staff skills, competencies, and strengths with the work required and unique challenges associated with each operating unit within the organization.

HSAG also said that DVHA's continuous quality improvement focus and activities, and steady improvements over the five years have been substantive and have led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators.

Finally, HSAG has concluded that DVHA has demonstrated incremental and substantive growth and maturity which has led to its current role and functioning as a strong, goal-oriented, innovative, continuously improving Medicaid managed care organization model.
This growth is also evidenced in evaluation efforts as reflected by the 2012 CAHPS survey data on "Overall Rating of Health Plan": the percentage of beneficiaries that rated the health plan 8 out of 10 or higher improved from 68.1% in 2009 to 81.3% in 2012.

Examples of DVHA's success in enhancing the quality of care for beneficiaries during the GC Demonstration include the following data:

- DVHA had above-average performance (greater than the national HEDIS 75th percentile) in 2012 for the following HEDIS measures that also relate to quality of care:

  - ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
  - ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
  - ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits; Children's and
  - ✓ Adolescents' Access to Primary Care Practitioners (all indicators); and
  - ✓ Annual Dental Visits measure, which involve distinct provider specialties.

Vermont's Medicaid Managed Care Model's most recent Performance Improvement Project (PIP), Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure, received a score of 96% for all applicable evaluation elements, a score of 100% for critical evaluation elements and an overall validation status of Met indicating a finding of high confidence in the reported baseline and re-measurement results.

Drafting the CQS has allowed AHS to think strategically about quality data and management intervention activities. The CQS can guide monitoring and intervention activities for MCE and other AHS programs. The CQS will regularly guide reviewers and recommend corrective action/follow-up; additionally, it will guide AHS Senior Leadership, which will be an important step to ensuring the implementation of quality activities. AHS continues to promote and support ongoing efforts of transparency and sharing. There has also been significant improvement in the collaboration between AHS and DVHA and the other AHS Departments, as well as between other programs on quality activities. The plan to institute formal quality strategies on a regular basis will strengthen these collaborations and assure a forum for dialogue, review of interim results, follow-up of corrective action, sharing of best practices, and identification of systems changes. After the implementation of this CQS, the AHS reserves the right to make modifications after the data has been collected and deemed as necessary.

Appendix A

Choices for Care Systemic Assessment and Work Plan

Appendix B

Developmental Services Systemic Assessment and Work Plan

Appendix C

Traumatic Brain Injury Systemic Assessment and Work Plan

Appendix D

Community Rehabilitation and Treatment Systemic Assessment and Work Plan

Appendix E

Enhanced Family Treatment Systemic Assessment and Work Plan

Vermont Agency of Human Services (AHS) – Global Commitment to Health Comprehensive Quality Strategy (CQS)/State Transition Plan (STP)
Summary of Public Comment

Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS)/State Transition Plan (STP) is reviewed publicly and that public input is incorporated into the final version. Public meeting notices were advertised in the *Burlington Free Press* and posted on multiple state websites. In addition to the *Burlington Free Press* – the notice was sent to Agency of Human Services District Offices, the Medicaid and Exchange Advisory Board, Disability Aging and Independent Living Advisory Board, and the Developmental Services State Program Standing Committee. In addition, the public hearing date was published in the Agency of Administration Department of Libraries public meeting calendar. A formal public hearing was held on Thursday, April 21, 2017 from 1pm - 2pm at Waterbury State Office Complex (WSOC) in Waterbury Vermont. Public input received included:

- No individuals attended the public meeting.
- Written comment received during the 30-day public comment period by three (3) organizations/individuals.

After reviewing the written comment documents received, the state identified the comments in the table below. In an attempt to thoroughly capture stakeholder feedback - the state chose to break apart some commenter's statements into multiple comments. Also, to enhance readability, the state created headers for similar comments. Please note that comments are not further sorted by individual or organization – so multiple comments under the same header might (and in many cases do) belong to the same individual or organization. All public comment reference documents will be submitted to CMS in their entirety along with the CQS.

Public Comment Received on VT Global Commitment to Health Comprehensive Quality Strategy & State Responses

Outreach & Stakeholder Involvement

Public Comment	State Response
In conversations with people with developmental disabilities I am hearing that they have not been taken seriously nor has there been sufficient time for them to provide input to this document. We recommend that you extend the period for public input and actually solicit consumer input more directly from people with disabilities	Vermont is committed to ensuring that our statewide CQS is reviewed publicly and that public input is incorporated into the final strategy. A summary of public comments and agency response will be made available on August 25, 2017.
People with disabilities and their families need to be at the table when assessing how the HCBS we receive are in compliance with federal requirements. What is your plan for seeking out and including our opinions?	It is the state's expectation that stakeholders will be invited to participate in all phases of CQS review and in identifying areas for further action.
To date we feel that there has not been adequate involvement of people with disabilities and their families when you developed your CQS.	The CQS includes a description of the public input process, with a summary of public comments. Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii).

Person Centered Planning & Conflict Free Case Management

The document does not specifically address the issue of conflict free case management.	Vermont's rules and statutes currently require person-centered planning for all populations. The person-centered planning provisions of the HCBS rules at 42 CFR§441.301(c)(1), (2) and (3) became effective on March 17, 2014. These requirements are not subject to a phase in or transition period. Compliance with these requirements is being addressed by the ongoing monitoring and compliance requirements of the CQS.
The proposed CQS fails to address many aspects of the person-centered planning provisions of the HCBS rules at 42 CFR §441.301(c)(1), (2) and (3) which became effective on March 17, 2014.	Vermont is required to comply with the Home and Community Based Service (HCBS) regulations found at 42 CFR §441.301(c)(1), (2) and (3) pertaining to Person-Centered Planning, 42 CFR§441.301(c)(4) and (5) pertaining to Home and Community Based Settings, and 42 CFR §441.301(c)(6) pertaining to a Transition Plan for coming into compliance with Home and Community Based Settings requirements.

HCBS CQS July 2018 000085

1) Providers of HCBS for the individual, or those who have an interest in the individual or are employed by a provider of HCBS for the individual do not provide case management or develop the individual's person-centered plan. 42 CFR §441.301(c)(l)(vi);	
2) The setting in which the individual resides is chosen by the individual. 42 CFR §441.301(c)(2)(i);	
3) Natural unpaid supports are provided voluntarily to the individual in lieu of ... HCBS waiver services and supports. 42 CFR §44I.301(c)(2)(v).	
The proposed CQS fails to include information on the extent of Vermont's compliance with the person-centered planning rule and to describe specific steps it will take to come into compliance where necessary.	

Ongoing Monitoring & Oversight

Vermont programs that provide support, intervention, care for people with DD must have oversight	Compliance with the new requirements is addressed in the ongoing monitoring and compliance sections of the CQS. Each individual program must ensure that the key concepts of these sections are implemented.

Site Specific Assessment & Validation

It is not acceptable that agencies do not go through a comprehensive review including interviews/home visits with people with DD. This review must include interviewing recipients of services and assessing their well-being.	The State is using a survey to assess specific settings in which HCBS are provided to determine whether they are in compliance with the new HCBS setting rules. The survey is intended to be administered as a provider self-assessment. Results of this survey will help determine remedial actions that must be taken by the state and providers to bring the specific settings into compliance. A consumer survey is being used to validate the provider self-assessment results. The information captured via the survey is linked to a specific setting in which HCBS are provided.

Site Specific Remediation

Despite the fact that Vermont is considered an "Inclusion" State there are many aspects of the current systems that reflect an institutionalization bias.	The State is using a survey to assess specific settings in which HCBS are provided to determine whether they are in compliance with the new

HCBS CQS July 2018 000086

There are group homes that have been constructed to have various doors or walls to indicate separate residency; however, they are basically ICF MR and should be dismantled.	HCBS setting rules. The survey is intended to be administered as a provider self-assessment. Results of this survey will help determine remedial actions that must be taken by the state and providers to bring the specific settings into compliance. Please see the CQS Relocation Plan and Process Section for more detail re: settings that are not able or willing to comply with the new HCBS regulations.

General Comments

The CQS does not describe how the state will ensure that the person receiving services will be supported to lead the process of making his/her person-centered service plan.	
The CQS does not outline how you plan to ensure that the setting a person lives in is truly chosen by the person.	
The CQS fails to outline how you will require service providers to foster the development of natural supports in a person's life.	
Table 9 describes HCBS regulatory requirements related to HCBS settings and "Examples of Acceptable Practice." While Table 9 does include many of the regulatory requirements found in the HCBS rules, it fails to include the "setting options" requirement found at 42 CFR §44I.301(c)(4)(ii).	
Table 9 fails to include "Examples of Best Practices" related to the aforementioned requirement.	

HCBS CQS July 2018 000087

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Tuesday, April 10, 2018 4:44 PM
To: Harrigan, Emma; Reed, Frank; Tierney-Ward, Megan; Courcelle, Andre; McFadden, Clare; Omland, Laurel; Clark, Bill; O'Neill, Chris; Robson, Dana; Singer, Patricia
Subject: FW: Vermont Statewide Transition Plan - CMS feedback for final approval
Attachments: Proposed VT HCBS Milestone Template April 10, 2018.pdf

Hi Everyone – just wanted to let you know that I submitted the attached HCBS Milestone Template to CMS today (see below). I will be sure to share any feedback with you. Best,

Shawn

From: Skaflestad, Shawn
Sent: Tuesday, April 10, 2018 3:27 PM
To: 'Richardson, Ondrea D. (CMS/CMCS)' <ondrea.richardson@cms.hhs.gov>
Cc: Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>; 'MacKenzie, Michele (CMS/CMCS)' <Michele.MacKenzie@cms.hhs.gov>; 'Lowe, Serena (ACL)' <Serena.Lowe@acl.hhs.gov>; 'Francis, Crystal (CMS/CMCHO)' <Crystal.Francis@cms.hhs.gov>; 'lnuss@neweditions.net' <lnuss@neweditions.net>; 'Beasley, Michelle (CMS/CMCHO)' <Michelle.Beasley@cms.hhs.gov>; 'Hill, Amanda C. (CMS/CMCS)' <Amanda.Hill@cms.hhs.gov>; 'cdiehl@neweditions.net' <cdiehl@neweditions.net>; Berliner, Ashley <Ashley.Berliner@vermont.gov>
Subject: RE: Vermont Statewide Transition Plan - CMS feedback for final approval

Hi Ondrea,

I recently met with our HCBS Implementation team to review the feedback provided below. The group does not have any questions or concerns re: the contents of the email currently. I will be sure to reach out to you if any questions or concerns should arise in the future. Attached is Vermont's updated milestone template. The chart reflects milestones and anticipated dates for completing the following HCBS implementation activities: site-specific settings assessments, validation activities, heightened scrutiny, ongoing monitoring of compliance, remediation planning/implementation, communications with beneficiaries, and relocation.

Please note that after modifying the STP to address the feedback below, Vermont plans to post its updated STP for public comment here prior to resubmitting for consideration of final approval. Anticipated STP resubmission date is **January 17, 2019**. Please be sure to let me know if you would like to discuss any of the items contained in the attached template.

Regards,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
Agency of Human Services
280 State Drive Center Building
3rd Floor – E310-1
Waterbury, VT 05671-1000
Office: (802) 241-0961
Cell Phone: (802) 585-4410

Fax: 802-241-0450

Find out how Vermonters are doing with the AHS Results Scorecard.
(Access through Internet Explorer 10, Firefox, or Google Chrome).

From: Skaflestad, Shawn
Sent: Wednesday, March 07, 2018 12:51 PM
To: 'Richardson, Ondrea D. (CMS/CMCS)' <ondrea.richardson@cms.hhs.gov>
Cc: Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>; MacKenzie, Michele (CMS/CMCS) <Michele.MacKenzie@cms.hhs.gov>; Lowe, Serena (ACL) <Serena.Lowe@acl.hhs.gov>; Francis, Crystal (CMS/CMCHO) <Crystal.Francis@cms.hhs.gov>; lnuss@neweditions.net; Beasley, Michelle (CMS/CMCHO) <Michelle.Beasley@cms.hhs.gov>; Hill, Amanda C. (CMS/CMCS) <Amanda.Hill@cms.hhs.gov>; cdiehl@neweditions.net; Berliner, Ashley <Ashley.Berliner@vermont.gov>
Subject: RE: Vermont Statewide Transition Plan - CMS feedback for final approval

Ondrea,

I will share this email with the members of Vermont's HCBS Implementation Team and be sure to get back in touch to discuss any questions or concerns we might have re: its contents. I look forward to working with you to obtain final approval of Vermont's STP.

Best,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
Agency of Human Services
280 State Drive Center Building
3rd Floor – E310-1
Waterbury, VT 05671-1000
Office: (802) 241-0961
Cell Phone: (802) 585-4410
Fax: 802-241-0450

Find out how Vermonters are doing with the AHS Results Scorecard.
(Access through Internet Explorer 10, Firefox, or Google Chrome).

From: Richardson, Ondrea D. (CMS/CMCS) <ondrea.richardson@cms.hhs.gov>
Sent: Thursday, March 01, 2018 12:04 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>; Hickman, Selina <Selina.Hickman@vermont.gov>; MacKenzie, Michele (CMS/CMCS) <Michele.MacKenzie@cms.hhs.gov>; Lowe, Serena (ACL) <Serena.Lowe@acl.hhs.gov>; Francis, Crystal (CMS/CMCHO) <Crystal.Francis@cms.hhs.gov>; lnuss@neweditions.net; Beasley, Michelle (CMS/CMCHO) <Michelle.Beasley@cms.hhs.gov>; Hill, Amanda C. (CMS/CMCS) <Amanda.Hill@cms.hhs.gov>; cdiehl@neweditions.net; Richardson, Ondrea D. (CMS/CMCS) <ondrea.richardson@cms.hhs.gov>
Subject: Vermont Statewide Transition Plan - CMS feedback for final approval

Hi Shawn,

I would like to take this opportunity to introduce myself and to inform you that I will be working with you on the STP moving forward.

As a follow up to your initial approval, please see below additional CMS feedback to assist the state with final approval of the STP. Please let us know when you are available to discuss any questions or concerns you might have. Also please share this email with any other members of your team who may need it.

[PLEASE NOTE: It is anticipated that the state will need to go out for public comment once these changes are made and prior to resubmitting to CMS for consideration of final approval. The state is requested to provide a timeline and anticipated date for resubmission as soon as possible.]

Date of STP Submission: 11/30/2017

Person-Centered Planning

CMS requests the state clarify in the CQS that Person-Centered Planning criteria do not have a phase-in allowance; these criteria were effective March 17, 2014.

Site-Specific Settings Assessment Process

- The STP is silent regarding the number of settings to be assessed for each service population group with the exception of Developmental Disability Services. Please provide the total number of settings subject to the HCBS Settings Rule by specialized service population group.
- ***Group Non-residential Settings: As a reminder, any setting in which individuals are clustered or grouped together for the purposes of receiving HCBS must be assessed and validated by the state for compliance with the rule. This includes all group residential and non-residential settings (including but not limited to prevocational services, group supported employment and group day habilitation activities). The state may presume that any setting where individualized services are being provided in typical community settings comport with the rule.*** The STP indicates that except for limited instances found in the DDS service system, the state does not support disability specific or segregated day treatment centers or programs. ***Please confirm that the STP accurately includes all group residential and non-residential settings in its assessment and validation activities.***

- ***Provider Self-Assessment Surveys:*** The state has developed electronic surveys and provided links to the survey tools. The STP does not provide information regarding the state's strategy to ensure each setting has completed a self-assessment. The STP states "To increase the response rate, a process will be created to follow-up with providers failing to meet requested response timeframes. Based on the results of the survey, an authorized representative of each provider will attest in writing whether they believe that their organization's rules and policies are either fully compliant with the new rules or that remediation is necessary (p.13)."
    - Please confirm in the STP that providers completed a distinct self-assessment for each individual setting providing Medicaid-funded HCBS.
    - Please confirm the self-assessment process evaluates the experience of individual's receiving HCBS in each setting.

- ***Individual, Private Homes***: The state may make the presumption that privately-owned or rented homes and apartments of people living with family members, friends, or roommates meet the HCBS settings criteria if they are integrated in typical community neighborhoods where people who do not receive HCBS also reside. A state will generally not be required to verify this presumption. However, the state must outline what it will do to monitor compliance of this category of settings with the regulatory criteria over time. Note, settings where the

beneficiary lives in a private residence owned by an unrelated caregiver (who is paid for providing HCBS services to the individual) are considered provider-owned or controlled settings and should be evaluated as such.

Validation of HCBS Settings

States are responsible for assuring that all HCBS settings comply with the settings criteria. States may use a combination of various strategies to assure that each setting is properly validated (including but not limited to state onsite visits; data collection on beneficiary experiences and consumer feedback; leveraging of existing case management, licensing & certification, and quality management review processes; partnerships with other federally-funded state entities, including but not limited to Developmental Disability and aging networks; and state review of data from operational entities, such as managed care organizations (MCOs) or regional boards/entities, provider policies, consumer surveys, and feedback from external stakeholders), so long as compliance with each individual setting is validated by at least one methodology beyond the provider self-assessment.

The STP indicates the state will develop a plan to validate the results of the provider-specific self-assessment during Phase 2 due 12/31/16. "At this time, the state plans to validate the results using a mixed-methods approach – using consumer survey as well as data from related oversight and monitoring activities that use a variety of desk and onsite review methodologies and tools (p. 12)."

- Please include additional details in the STP about the state's plan to validate the provider self-assessments, and how the state will assure that each setting providing Medicaid-funded HCBS will be assessed and validated, using at least one independent validation strategy.
- Please provide information in the STP about the state's plan for site visits, including the number of settings to receive site visits and when and how they will occur.

Reporting of Setting Validation Results: Once the state's validation activities have been completed, please provide an updated chart of the number of sites falling into categories of compliance (fully compliant with the settings criteria, could come into full compliance with modifications, cannot comply with the federal settings criteria, or are presumptively institutional in nature).

Remediation Strategies

- ***Site-Specific Remediation:*** The STP indicates that "Providers that indicate that remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider self-assessment. The State will work with providers, through a corrective action process, to improve the quality of care and the setting characteristics to align with State and federal HCBS standards (p. 13)." Please provide the following additional information:
  - Describe the process that the state will take to assure that any discrepancies between the consumer responses and/or other validation strategy and provider self-assessments are addressed.
  - Describe in more detail what state strategies will be employed to support site-specific remediation.
  - Describe the process the state will employ to track progress with site-specific corrective action plans to ensure HCBS settings will achieve compliance by the March 2022 deadline.

Communication with and Support to Beneficiaries when a Provider will not be Compliant

Please provide a detailed strategy for assisting participants receiving services from providers not willing or able to come into compliance by the end of the transition period. CMS asks that Vermont include the following details of this process in the state's next installation of its STP:

- Please include a timeline and a description of the processes for assuring that beneficiaries, through the person-centered planning process, will be given the opportunity, the information and the supports necessary to make an informed choice among options for continued service provision, including in an alternate setting that

aligns, or will align by the end of the transition period, with the regulation. CMS requests that this description and timeline specifically explain how the state intends to assure beneficiaries that they will be provided sufficient communication and support including options among compliant settings, and assurance that there will be no disruption of services during the transition period.

- Please provide an estimate of the number of individuals who may need assistance in this regard.

Non-Disability Specific Settings: Please provide clarity on the manner in which the state will ensure that beneficiaries have access to services in non-disability specific settings among their service options for both residential and non-residential services. The STP should also indicate the steps the state is taking to build capacity among providers to increase access to non-disability specific setting options across home and community-based services.

Ongoing Monitoring of Settings

The STP indicates "The state will monitor progress on Corrective Action Plans and will also begin routine monitoring of compliance with the requirements of the new rules during the Transition period for providers for whom no Corrective Action Plan is in effect. *Monitoring of compliance with the HCBS Final Rule will occur long after the March 17, 2019, federal implementation date. On an ongoing basis, the state will ensure effective monitoring of provider settings to support continued compliance with all applicable HCB settings requirements. The Vermont Managed Care Entity (MCE) will have primary operational responsibility for monitoring, with oversight from AHS and an External Quality Review Organization. MCE staff will monitor member experience and compliance with HCB settings requirements by modifying its current monitoring/oversight tools to include the new HCBS requirements.* If the MCE identifies a compliance issue during a review, the provider will be notified of the issue and remediation measures will be taken, including but not limited to the development of a CAP, to address the issue. The provider will submit periodic updates to the MCE on the status of implementation. AHS and an External Quality Review Organization will be responsible for overseeing the MCE and will ensure that they adhere to all applicable CMS guidance (page 15). "

- Please add information on the estimated timeframes for implementing each element of the oversight and monitoring plan.

Heightened Scrutiny

As a reminder, the state must clearly lay out its process for identifying settings that are presumed to have the qualities of an institution. These are settings for which the state must submit information for the heightened scrutiny process if the state determines, through its assessments, that these settings do have qualities that are home and community-based in nature and do not have the qualities of an institution. If the state determines it will not submit information, the institutional presumption will stand and the state must describe the process for determining next steps for the individuals involved. Please only submit those settings under heightened scrutiny that the state believes will overcome any institutional characteristics and can comply with the federal settings criteria. There are state examples of heightened scrutiny processes available upon request, as well as several tools and sub-regulatory guidance on this topic available online at http://www.medicaid.gov/HCBS.

- Please include further details about the criteria or deciding factors that will be used consistently across reviewers to make a final determination regarding whether or not to move a setting forward to CMS for heightened scrutiny review.

Milestones

A milestone template has been completed by CMS with timelines identified in the STP and has been sent to the state for review. CMS requests that the state review the information in the template and send the updated document to CMS. The chart should reflect anticipated milestones for completing systemic remediation, settings assessment and remediation, heightened scrutiny, communications with beneficiaries and ongoing monitoring of compliance.

Ondrea D. Richardson
Health Insurance Specialist |Centers for Medicare & Medicaid Services | Center for Medicaid & CHIP Services | Disabled and Elderly Health Programs Group | Division of Long Term Services and Supports
7500 Security Boulevard| Baltimore, MD 21244-1850 | PHONE: 410-786-4606 | ✉: Ondrea.Richardson@cms.hhs.gov

PROPOSED VERMONT HCBS MILESTONE TEMPLATE: April 10, 2018

SECTION	TOPIC	MILESTONE	SUB-MILESTONE	DUE DATE
I	**Site-specific Assessments**	Completion of site-specific assessment		**9/17/2018**
II	**Validation Activities**	Identify plan to validate results/outcomes of site specific settings assessment.		**Completed**
		Completion of validation activities		**9/17/2018**
		Once the state's validation activities have been completed, provide an updated chart of the number of sites falling into categories of compliance (a) fully compliant with the settings criteria, (b) could come into full compliance with modifications, (c) cannot comply with the federal settings criteria, or (d) are presumptively institutional in nature.		**10/17/2018**
		Identification of settings that will not remain in the HCBS System		**10/17/2018**
III	**Heightened Scrutiny**	Identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider		**10/17/18**
		Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		**11/17/18**
		Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment		**11/17/18**
IV	**Ongoing Monitoring of the Settings**	Provide information on the estimated timeframes for implementing each element of the oversight and monitoring plan.		**11/17/18**
V	**Site-specific Remediation: Planning**	Identify remedial action steps (i.e., corrective action plan) for settings based on site specific settings assessment and validation activity.		**11/17/2018**
		Incorporate results of settings analysis into final version of the STP and release for public comment		**11/17/2018**

HCBS CQS July 2018 000094

VI	**CMS Submission**	Submit STP with Heightened Scrutiny information to CMS for review		**1/17/2019**
		Anticipated CMS Approval		***3/17/2019***
VII	**Site-specific Remediation: Implementation**	Manage site-specific Remediation		
			Completion of provider remediation: 25%	**7/17/2021**
			Completion of provider remediation: 50%	**10/17/2021**
			Completion of provider remediation: 75%	**1/17/2022**
			Completion of provider remediation: 100%	**3/17/2022**
VIII	**Notification**	Notify member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required.		
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 25%	**6/17/2020**
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 50%	**9/17/2020**
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 75%	**12/17/2020**
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 100%	**3/17/2021**
IX	**Relocation**	Relocate beneficiaries across all providers.		
			Complete beneficiary relocation across all providers: 25%	**6/17/2021**
			Complete beneficiary relocation across all providers: 50%	**9/17/2021**
			Complete beneficiary relocation across all providers: 75%	**12/17/2021**
			Complete beneficiary relocation across all providers: 100%	**3/17/2022**

HCBS CQS July 2018 000095

HCBS CQS July 2018 000096

An official website of the United States government

Home & Community Based Services

In 2014, **53%** of all Medicaid long term care spending was on **home & community based services.**

Other Services: $71.2 Billion

HCBS Services: $80.6 Billion

Source: 2014 LTSS Expenditure Report

Home and community based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Long-Term Services and Supports

Policy and Program Topics

- Home & Community Based Services Authorities
- Home & Community Based Services Guidance
- Home & Community Based Services Training Series
- Statewide Transition Plans
- Home & Community Based Services Technical Assistance for States

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Related Sites

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CMS.gov

HHS.gov

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InsureKidsNow.gov

Medicare.gov

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Medicaid.gov
Keeping America Healthy

Centers for Medicare & Medicaid Services

A federal government managed website by the
Centers for Medicare & Medicaid Services.
7500 Security Boulevard Baltimore, MD 21244

HCBS CQS July 2018 000099

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Tuesday, April 18, 2017 11:22 AM
To: Tierney-Ward, Megan; Courcelle, Andre; Gerstenberger, Roy; Harrigan, Emma; Reed, Frank; Omland, Laurel; Clark, Bill
Subject: FW: VT Milestone Template
Attachments: VT Milestone Template.docx; ATT00001.htm

Hi All – please see the attached draft HCBS implementation milestone template put together by CMS. I am going to look for some time for us to get together and discuss – but in the meantime please feel free to forward any comments, concerns, and/or questions.

Thank you,

Shawn

From: Hickman, Selina
Sent: Tuesday, April 18, 2017 8:26 AM
To: Skaflestad, Shawn
Subject: Fwd: VT Milestone Template

Sent from my iPhone

Begin forwarded message:

> **From:** "MacKenzie, Michele (CMS/CMCS)" <Michele.MacKenzie@cms.hhs.gov>
> **Date:** April 18, 2017 at 7:54:02 AM EDT
> **To:** "Hickman, Selina" <Selina.Hickman@vermont.gov>
> **Cc:** "Crystal, Frances C. (CMS/CMCS)" <Frances.Crystal@cms.hhs.gov>, "Loehr, Jessica S. (CMS/CMCS)" <Jessica.Loehr@cms.hhs.gov>, "Susan Cahn (cahn-susan@norc.org)" <cahn-susan@norc.org>
> **Subject: VT Milestone Template**
>
> Good morning, Selina;
>
> Attached please find the milestone template that was completed with milestones gleaned from your STP. Please review and revise as appropriate and return to me. We will then have the milestones uploaded into the Liberty system. The SOTA call that will be scheduled in May will provide instruction regarding how to edit and track milestones in the Liberty system. In the meantime, please feel free to contact me if you have any questions. You can also access the State User Guide on the Liberty system for assistance.
>
> Thank you,
>
> Michele
>
> Michele MacKenzie
> Division of Long Term Services and Supports
> Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
michele.mackenzie@cms.hhs.gov
(p) 410.786.5929

Milestone Template -- DRAFT

Background

In order to collect consistent information on the implementation of the HCB Settings regulations and Statewide Transition Plan (STP), CMS has identified a standard set of milestones to track across states. Since each state is different, the milestone must align with the Statewide Transition Plan (STP) evidence. States may need to provide more than one date for a particular milestone because the states will report completion in percentages, such as 25% or 50% complete. This approach will provide CMS insight in regards to the status of completion pertaining to particular milestones.

Instructions and Reminders

The following milestone list provides CMS the opportunity to track progress in implementation of each state's STP. Please provide dates for each milestone and where possible, the corresponding page number in the STP. Per the SOTA call on February 4, 2016, the state will receive email reminders 30 days prior to the due date of each milestone input into the system and when milestones are past due. States will also have the opportunity to update CMS on the milestones below through the HCB Settings website.

- All dates included in the template below should also align with the STP.
- The red italic text provides additional details related to each milestone. Please reach out to CMS with specific questions.
- Some milestones may have the same proposed due dates-as these steps may be undertaken simultaneously.
- States are encouraged to provide additional details on each milestone in the description column below. The description field will be transferred and available for viewing on the HCB Settings Website.

This template was completed using the June 10, 2016 STP submission.

Milestone	Description	Proposed End Date	STP Page No.
Systemic Assessment and Remediation			
Completion of systemic assessment *[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]*	Complete crosswalk of state regulations compared to new federal HCBS requirements (scored as alignment, partial alignment, silent, or non-compliant)	Completed (12/31/2015)	HCBS DS Timeline; p. 7 (STP)
Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.		**Please complete**	
Implementation of new rules and regulations: 50% complete *[The date when at least 50% of all rules, regulations, and statutes identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]*		**Please complete**	
Implementation of new rules and regulations: 100% complete *[The date when all rules, regulations, and statutes (100%) identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]*		**Please complete**	
Site-specific Assessments			

HCBS CQS July 2018 000103

Completion of site-specific assessment *[The date when the overall completion of the site-specific assessment, including review of all settings and the validation of assessment results.]*	Determine settings ability to accommodate new HCBS requirements (with scoring outcomes/results) **CFC, DS, and TBI** **SED and CRT**	 Completed 6/30/2016 3/31/2017	HCBS DS Timeline
Incorporate results of settings analysis into final version of the STP and release for public comment	Share site specific settings assessment and validation plan with external stakeholders **CFC, DS, and TBI** **SED and CRT**	 Completed (7/1/2016) 3/31/2017	HCBS DS Timeline
Submit final STP to CMS		**Please complete**	
Site-specific Remediation[1]			
Completion of residential provider remediation: 25% *[The date when approximately 25% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*	Identify remedial action steps (i. e, corrective action plan) for settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment. **CFC, DS, and TBI** **SED and CRT**	 Completed (9/30/2016) 9/30/2017	HCBS DS Timeline
Completion of residential provider remediation: 50%		**Please complete**	

Commented [MM1]: The HCBS DS Timeline does not distinguish between residential and nonresidential provider remediation; therefore these milestones are listed under both.

HCBS CQS July 2018 000104

[The date when approximately 50% of residential providers have completed the necessary remediation (of those providers that require remediation). . Please provide additional details on settings in the description.]			
Completion of residential provider remediation: 75% *[The date when approximately 75% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of residential provider remediation: 100% *[The date when all residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 25% *[The date when approximately 25% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*	Identify remedial action steps (i. e, corrective action plan) for settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment. **CFC, DS, and TBI** **SED and CRT**	 Completed (9/30/2016) 9/30/2017	HCBS DS Timeline

Commented [MM2]: The HCBS DS Timeline does not distinguish between residential and nonresidential provider remediation; therefore these milestones are listed under both.

Completion of nonresidential provider remediation: 50% *[The date when approximately 50% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 75% *[The date when approximately 75% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 100% *[The date when all nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Identification of settings that will not remain in the HCBS System *[The date those settings that are considered institutional or are not willing to remediate will be identified for removal from the HCBS System]*		**Please complete**	
Heightened Scrutiny[2]			
Identification of settings that overcome the presumption and will be	Identify process and settings presented for heightened scrutiny – if necessary.	Complete (Please complete)	HCBS DS Timeline

HCBS CQS July 2018 000106

Commented [MM3]: Please provide a completion date.

submitted for heightened scrutiny and notification to provider			
Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		**Please complete**	
Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment		**Please complete**	
Submit STP with Heightened Scrutiny information to CMS for review		**Please complete**	
Relocation			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 25% *[The date when members, guardians, case managers, etc. in approximately 25% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 50%		**Please complete**	

HCBS CQS July 2018 000107

[The date when members, guardians, case managers, etc. in approximately 50% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 75% *[The date when members, guardians, case managers, etc. in approximately 75% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 100% *[The date when members, guardians, case managers, etc. in all providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 25%	Identify VT plan to relocate consumers – if necessary. Currently	**Please complete**	HCBS DS Timeline

HCBS CQS July 2018 000108

[The date when beneficiaries in approximately 25% of providers have been relocated. Please provide additional details on settings in the description.]	in CQS – but may need to be modified as we learn more.		
Complete beneficiary relocation across all providers: 50% *[The date when beneficiaries in approximately 50% of providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 75% *[The date when beneficiaries in approximately 75% of providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 100% *[The date when beneficiaries in all providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	

[1]This section includes only those providers where remediation was required.
[2]The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

HCBS CQS July 2018 000109

Quarterly reporting: Per the initial and final approval STP letter, CMS requests quarterly updates on the HS progress. The following milestones will provide a system to monitor the submission of these reports.

Milestone	Description	Proposed End Date	STP Page No.
Quarterly progress reporting updates			
Quarterly progress update *[First quarter after initial and/or final approval.]*			
Quarterly progress update *[Second quarter after initial and/or final approval.]*			
Quarterly progress update *[Third quarter after initial and/or final approval.]*			
Quarterly progress update *[Fourth quarter after initial and/or final approval.]*			
Quarterly progress update *[Fifth quarter after initial and/or final approval.]*			
Quarterly progress update *[Sixth quarter after initial and/or final approval.]*			
Quarterly progress update *[Seventh quarter after initial and/or final approval.]*			

HCBS CQS July 2018 000110

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Friday, November 17, 2017 11:47 AM
To: Courcelle, Andre
Subject: Fwd: Once final TBI work plan CMS issue
Attachments: FINAL TBI Work Plan 6.7.docx

Are you able to handle this?

Get Outlook for iOS

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 10:45:03 AM
To: Tierney-Ward, Megan; Courcelle, Andre
Subject: Once final TBI work plan CMS issue

After looking over the TBI work plan – CMS had the following comment:

The state should clarify that its remediation will bring the program into compliance with the final rule by including the settings criteria.

I interpret this to mean that they were not happy that our proposed improvements (column #3) were not linked to the specific regulation (column #1).

Can you please go through and line up the columns in the attached document.

Thank you,

Shawn

Department of Disabilities, Aging and Independent Living (DAIL)
Traumatic Brain Injury Program HCBS Work Plan

This document represents the DAIL's improvement and action steps to strengthen Vermont's Traumatic Brain Injury (TBI)home and community-based services system. It was developed as part of the State's Comprehensive Quality Strategy (CQS). The CQS calls for the systemic assessment of the alignment of Long Term Services and Supports with recent federal Home and Community Based Services standards related to person-centered planning and home and community based settings. The CQS also calls for an improvement and quality monitoring plan to address any areas of weakness based on the findings of the systematic assessment. TBI planning included the following activities:

- Presentation of the State's Proposed Comprehensive Quality Strategy and its relationship to the HCBS regulations to the DAIL Advisory Board (August 13, 2015);
- A review of policies and rules governing TBI operations (*State of Vermont Comprehensive Quality Strategy Systemic Assessment Section III State Standards: Home and Community Based Services Specialized Health Population: Traumatic Brain Injury Services* (*Pacific Health Policy Group, March 1, 2016*);
- Distribution of and a solicitation for input on a draft work plan and alignment findings (by April 30, 2016);
- Posting of the draft work plan and alignment findings to the DAIL Adult Services Division and DVHA websites (by June 15, 2016);
- Presentation of the draft work plan and alignment findings at the TBI Advisory Board (May 17, 2016);
- Final collection of stakeholder feedback by July 15, 2016; and
- The State's review of stakeholder feedback and incorporation of changes in final work plan and findings report (July 31, 2016).

The primary lead for TBI program improvements/actions steps rests with the Department of Disabilities, Aging and Independent Living (DAIL). All improvements/actions steps will be managed in collaboration with program stakeholders, the Vermont Agency of Human Services (AHS) and the Department of VT Health Access (DVHA). The work plan will commence in June 2016 and is anticipated to be complete by May 2017.

TBI - Shared Living and Home-Based Services

Regulation: Settings Requirements	Findings	Proposed Improvements/Action Steps
#1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS	Rehabilitation services assume community living; guidelines are silent on TBI long term services and supports program	a. DAIL to provide a self-assessment tool to TBI providers. b. DAIL to update TBI Provider Manual – Sec. V Service Standards c. DAIL to update the TBI Provider Manual – Sec. IV Agency Standards d. DAIL to adapt the Choices for Care Adult Family Care shared living agreement for use with TBI. e. DAIL to update the Individual Support Plan Guidelines for TBI services. f. DAIL to solicit stakeholder feedback on updated documents. g. DAIL to incorporate feedback into documents. h. DAIL to publish revised documents and distribute to stakeholders. i. DAIL to incorporate related elements of consumer experience of care into the DAIL annual consumer survey j. DAIL to provide training and technical assistance to providers and stakeholders as needed. k. AHS, DAIL and DVHA to evaluate results of the provider
#6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a lease,	Silent - Shared living agreement standards do not exist.	

HCBS CQS July 2018 000113

Regulation: Settings Requirements	Findings	Proposed Improvements/Action Steps
residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*		self-assessment tools. l. DAIL to coordinate ASD quality activities with AHS and DVHA quality assurances under the Global Commitment Comprehensive Quality Plan (CQP). m. DAIL to update TBI Provider Manual Sec. IV, V to include "Agreement for live in Care" n. DAIL to update TBI Provider manual Sec. IV, V, DAIL Home Safety and Accessibility Standards o. DAIL to update TBI Participant Rights & Responsibilities
#8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	Standards are silent.	
#10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.		
#11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.		
#12. Individuals are able to have visitors of their choosing *at any time.*		
#14. Modification to HCBS Settings Requirements.	Provider documentation requirements are silent and could be stronger regarding modifications to the settings requirements.	

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
#1. Includes people chosen by the individual and led by person or legal rep where possible	Guidance for Non-DA/SSA programs is missing.	a. DAIL to provide a self-assessment tool to TBI providers. b. DAIL, AHS and DVHA to evaluate results of the provider self-assessment tools.

HCBS CQS July 2018 000114

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
#2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	Guidance for Non-DA/SSA programs is missing.	c. DAIL to update the TBI Provider Manual – Program Standards section d. DAIL to update the TBI Provider Manual – Agency Standards sec. IV e. DAIL to update the Individual Support Plan Guidelines f. DAIL to update the Participant Rights & Responsibilities g. DAIL to solicit stakeholder feedback on updated documents. h. DAIL to incorporate feedback into documents. i. DAIL to publish revised documents and distribute to stakeholders. p. DAIL to provide training and technical assistance to providers and stakeholders as needed. j. DAIL to Coordinate ASD quality activities with DVHA and AHS quality assurances under the Global Commitment Comprehensive Quality Plan (CQP) k. DAIL to update TBI Provider Manual Sec. IV l. DAIL to update TBI Provider Manual Sec. IV to include Behavior Support Guidelines m. DAIL to update TBI Provider Manual Sec. VII 3. n. DAIL to update TBI Provider Manual Sec. IV,V o. DAIL to update TBI Provider Manual Sec. IV, Sec. V p. DAIL to update TBI Provider Manual Sec. VI and VII q. DAIL to update TBI Provider Manual Sec. IV and V, r. DAIL to update ISP Guidelines
#3. Is timely, occurs at times and locations of convenience to the individual	Standards are silent. Documentation requirements must be strengthened.	
#5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	Guidance does not include Conflict of Interest policies	
#6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*		
#8. Includes a method for the individual to request updates to the plan as needed	Monthly meeting expectations	

HCBS CQS July 2018 000115

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
	could be stronger	
#15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	Crisis services and proactive plans are part of the service package however specific guidelines for back-up plans, creating negotiated risk agreements and crisis plans do not exist.	
#19. Be distributed to the individual and other people involved in the plan. .	Guidelines indicate plans should be kept on file, but are silent on how copies are distributed	
#22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.	Monthly meeting expectations could be stronger.	

HCBS CQS July 2018 000116

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Thursday, March 09, 2017 1:34 PM
To: Tierney-Ward, Megan; Gerstenberger, Roy; Courcelle, Andre; Harrigan, Emma; Omland, Laurel; Hawes, Emily; Hamilton, Kathleen; Reed, Frank
Cc: Clark, Bill
Subject: HCBS CQS/STP Work Plan Milestones Meeting on Monday March 13th

Hi All,

The DAIL program surveys have been successfully transferred to the AHS SurveyGizmo (SG) account and the DMH survey transfer was initiated today. We expect the DMH surveys to be in our account by this Monday, March 13th. As far as provider survey next steps are concerned – we need to do the following:

- Create personalized messages (both content and look) that you would like to send to providers. SG offers customizable messages for invites, reminders, and thank yous. I can send you a template that you can modify. **As a group, we will need to determine the most efficient way to customize the look of your messages**.
- Upload a spreadsheet containing provider contact information. In order to do this, **I will need a spreadsheet from you with provider contact information (specifically emails)**. To date, I have set up 3 DAIL email campaigns (i.e., CFC providers, DS providers, and TBI providers). As a result, I will need a spreadsheet with provider contact information for each. I have also set up 3 DMH email campaigns (i.e., CRT providers, EFT providers, and EFT Parents/Guardians). Similar to DAIL – each will need a spreadsheet with contact information. I set up the email campaigns – so if these don't make sense – we can make adjustments.
- **Determine survey open and close dates**. I propose Monday, April 3rd as the day that DAIL provider surveys should be sent out – and Friday, April 28th as the closing date. As far as DMH is concerned – I propose May 1st and May 31st OR June 1st and June 30th. These dates are flexible – but we need to agree on dates ahead of the Comprehensive Quality Strategy (CQS – aka Vermont's State Transition Plan) public posting next Friday, March 17th.
- **Clarify a monitoring plan**. SG has numerous statistics that track message/survey delivery and completion. We need to determine how best to use the information available via the application to enhance response rates, flag concerns, and monitor any corrective actions.

Please keep in mind that these items relate to provider self-assessments only. We have an update meeting scheduled for this coming Monday, March 13th from 3:30pm-4:30pm. I would like to use some of this meeting to review this email, make some decisions, and determine next steps – including the administration of the consumer validation survey. If you would like to talk before our meeting, please feel free to email, call, or stop by.

Speak with you soon,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
Agency of Human Services
280 State Drive Center Building
3rd Floor – E310-1
Waterbury, VT 05671-1000
Office: (802) 241-0961
Cell Phone: (802) 585-4410

Fax: 802-241-0450

Find out how Vermonters are doing with the AHS Results Scorecard.
(Access through Internet Explorer 10, Firefox, or Google Chrome).

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Monday, June 12, 2017 4:03 PM
To: Gerstenberger, Roy; Hamilton, Kathleen; Tierney-Ward, Megan; Courcelle, Andre; Harrigan, Emma; Omland, Laurel
Cc: Clark, Bill
Subject: HCBS Implementation Team Next Steps
Attachments: VT Milestone Template.docx; CMCS Informational Bulletin new HCBS rules May 9, 2017.pdf

Hi All,

Below was the agenda for today's meeting. As you are probably aware, we received an informational bulletin (attached) from CMS on May 9th that changed 3/17/19 as the deadline for full compliance with the new federal regulations – to the deadline for final approval of the CQS/STP. 3/17/2022 becomes the new date to demonstrate full compliance. This gives us a bit more time to complete our provider assessments, validation activities, and document any corrective action plans. In addition, we get a bit more time to think about how ongoing monitoring and compliance fits in with our current practice.

This item segues nicely into the next – as we need to develop a work plan to help us get from current state to final approval. CMS has proposed a set of milestones and end dates for this work (attached). The task at hand is for us to agree on the milestones and propose realistic end dates. Please take some time to do this between now and next meeting. We have some time after the 2019 deadline to worry about developing a full compliance work plan.

Next, I wanted to share the HCBS provider survey response rates with you and determine next steps.

	COMPLETE	PARTIAL	NOT STARTED	NEXT STEPS
CFC	11 (26%)	8	24	
TBI	5 (45%)	1	5	
DS	17 (100%)	0	0	Set up meeting with QM staff.
CRT	2 (20%)	0	8	

As you can see, DS providers have completed 100% of their self-assessments. Great work Roy and Kathleen! My anticipated next step for them would be to set up a meeting with their QM folks to share individual provider responses – and develop a template to document any necessary corrective action plans. As far as the other programs are concerned – please let me know how I can help encourage additional providers to respond.

Finally, I was going to let you know about the status of Vermont's geographic exception request – and discuss with you the current way Case Management and HCBS services are provided for each program in each of the geographic regions of the state. I wanted to have a conversation with you folks – before proposing a draft response to CMS.

Agenda
June 12, 2017

1. *CMS Memo May 9, 2017*

2. *CMS Proposed Milestones and End Dates*

3. *HCBS Provider Survey – update*

4.CMS Follow Up – case management conflict of interest issue

Thank you,

Shawn

Milestone Template -- DRAFT

Background

In order to collect consistent information on the implementation of the HCB Settings regulations and Statewide Transition Plan (STP), CMS has identified a standard set of milestones to track across states. Since each state is different, the milestone must align with the Statewide Transition Plan (STP) evidence. States may need to provide more than one date for a particular milestone because the states will report completion in percentages, such as 25% or 50% complete. This approach will provide CMS insight in regards to the status of completion pertaining to particular milestones.

Instructions and Reminders

The following milestone list provides CMS the opportunity to track progress in implementation of each state's STP. Please provide dates for each milestone and where possible, the corresponding page number in the STP. Per the SOTA call on February 4, 2016, the state will receive email reminders 30 days prior to the due date of each milestone input into the system and when milestones are past due. States will also have the opportunity to update CMS on the milestones below through the HCB Settings website.

- All dates included in the template below should also align with the STP.
- The red italic text provides additional details related to each milestone. Please reach out to CMS with specific questions.
- Some milestones may have the same proposed due dates-as these steps may be undertaken simultaneously.
- States are encouraged to provide additional details on each milestone in the description column below. The description field will be transferred and available for viewing on the HCB Settings Website.

This template was completed using the June 10, 2016 STP submission.

Milestone	Description	Proposed End Date	STP Page No.
Systemic Assessment and Remediation			
Completion of systemic assessment *[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]*	Complete crosswalk of state regulations compared to new federal HCBS requirements (scored as alignment, partial alignment, silent, or non-compliant)	Completed (12/31/2015)	HCBS DS Timeline; p. 7 (STP)
Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.		**Please complete**	
Implementation of new rules and regulations: 50% complete *[The date when at least 50% of all rules, regulations, and statutes identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]*		**Please complete**	
Implementation of new rules and regulations: 100% complete *[The date when all rules, regulations, and statutes (100%) identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]*		**Please complete**	
Site-specific Assessments			

HCBS CQS July 2018 000122

Completion of site-specific assessment *[The date when the overall completion of the site-specific assessment, including review of all settings and the validation of assessment results.]*	Determine settings ability to accommodate new HCBS requirements (with scoring outcomes/results) **CFC, DS, and TBI** **SED and CRT**	 Completed 6/30/2016 3/31/2017	HCBS DS Timeline
Incorporate results of settings analysis into final version of the STP and release for public comment	Share site specific settings assessment and validation plan with external stakeholders **CFC, DS, and TBI** **SED and CRT**	 Completed (7/1/2016) 3/31/2017	HCBS DS Timeline
Submit final STP to CMS		**Please complete**	
Site-specific Remediation[1]			
Completion of residential provider remediation: 25% *[The date when approximately 25% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*	Identify remedial action steps (i. e, corrective action plan) for settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment. **CFC, DS, and TBI** **SED and CRT**	 Completed (9/30/2016) 9/30/2017	HCBS DS Timeline
Completion of residential provider remediation: 50%		**Please complete**	

Commented [MM1]: The HCBS DS Timeline does not distinguish between residential and nonresidential provider remediation; therefore these milestones are listed under both.

[The date when approximately 50% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]			
Completion of residential provider remediation: 75% *[The date when approximately 75% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of residential provider remediation: 100% *[The date when all residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 25% *[The date when approximately 25% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*	Identify remedial action steps (i. e, corrective action plan) for settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment. **CFC, DS, and TBI** **SED and CRT**	 Completed (9/30/2016) 9/30/2017	HCBS DS Timeline

HCBS CQS July 2018 000124

Commented [MM2]: The HCBS DS Timeline does not distinguish between residential and nonresidential provider remediation; therefore these milestones are listed under both.

Completion of nonresidential provider remediation: 50% *[The date when approximately 50% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 75% *[The date when approximately 75% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 100% *[The date when all nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Identification of settings that will not remain in the HCBS System *[The date those settings that are considered institutional or are not willing to remediate will be identified for removal from the HCBS System]*		**Please complete**	
Heightened Scrutiny[2]			
Identification of settings that overcome the presumption and will be	Identify process and settings presented for heightened scrutiny – if necessary.	Complete **(Please complete)**	HCBS DS Timeline

HCBS CQS July 2018 000125

Commented [MM3]: Please provide a completion date.

submitted for heightened scrutiny and notification to provider			
Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		**Please complete**	
Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment		**Please complete**	
Submit STP with Heightened Scrutiny information to CMS for review		**Please complete**	
Relocation			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 25% *[The date when members, guardians, case managers, etc. in approximately 25% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 50%		**Please complete**	

HCBS CQS July 2018 000126

[The date when members, guardians, case managers, etc. in approximately 50% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 75% *[The date when members, guardians, case managers, etc. in approximately 75% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 100% *[The date when members, guardians, case managers, etc. in all providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 25%	Identify VT plan to relocate consumers – if necessary. Currently	**Please complete**	HCBS DS Timeline

HCBS CQS July 2018 000127

[The date when beneficiaries in approximately 25% of providers have been relocated. Please provide additional details on settings in the description.]	in CQS – but may need to be modified as we learn more.		
Complete beneficiary relocation across all providers: 50% *[The date when beneficiaries in approximately 50% of providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 75% *[The date when beneficiaries in approximately 75% of providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 100% *[The date when beneficiaries in all providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	

[1]This section includes only those providers where remediation was required.
[2]The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

HCBS CQS July 2018 000128

Quarterly reporting: Per the initial and final approval STP letter, CMS requests quarterly updates on the HS progress. The following milestones will provide a system to monitor the submission of these reports.

Milestone	Description	Proposed End Date	STP Page No.
Quarterly progress reporting updates			
Quarterly progress update *[First quarter after initial and/or final approval.]*			
Quarterly progress update *[Second quarter after initial and/or final approval.]*			
Quarterly progress update *[Third quarter after initial and/or final approval.]*			
Quarterly progress update *[Fourth quarter after initial and/or final approval.]*			
Quarterly progress update *[Fifth quarter after initial and/or final approval.]*			
Quarterly progress update *[Sixth quarter after initial and/or final approval.]*			
Quarterly progress update *[Seventh quarter after initial and/or final approval.]*			

HCBS CQS July 2018 000129

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: May 9, 2017

FROM: Brian Neale, Director

SUBJECT: **Extension of Transition Period for Compliance with Home and Community-Based Settings Criteria**

Health and Human Services Secretary Thomas E. Price, M.D. and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma, MPH, issued a letter to the nation's Governors on March 14, 2017, affirming the continued HHS and CMS commitment to partnership with states in the administration of the Medicaid program and noting key areas where we will improve collaboration with states and move towards more effective program management. One of the areas of the increased flexibility CMS intends to extend to states is in the provision of home and community-based services (HCBS), and this information will provide additional clarity on immediate steps taken to act on that commitment.

Promoting community integration for older adults and people with disabilities remains a high priority for CMS. We acknowledge the important work underway at the state level in implementing the regulation that finalized criteria for home and community-based settings appropriate for the provision of HCBS. State partners, stakeholders representing beneficiaries and their families, providers, and other community organizations have been collaborating with us, and with each other, to develop transition plans that would make the reforms described in the regulation a reality for over a million Medicaid beneficiaries receiving HCBS.

Language in the preamble to the final HCBS regulations governing services provided under sections 1915(c), 1915(i) and 1915(k) of the Social Security Act, in a response to comments submitted on the regulations proposing the settings criteria, recognized that compliance with the new regulations would be a complex process requiring a balancing of interests. As a result, CMS indicated that states were permitted to propose transition plans (i.e., Statewide Transition Plans) encompassing up to five years after the effective date of the regulations for settings reflected in existing state plans and waivers to come into compliance with the regulation.

In recognition of the significance of the reform efforts underway, CMS intends to continue to work with states on their transition plans for settings that were operating before March 17, 2014 to enable states to achieve compliance with the settings criteria beyond 2019. Consistent with the preamble language, states should continue progress in assessing existing operations and identifying milestones for compliance that result in final Statewide Transition Plan approval by March 17, 2019. However, in light of the difficult and complex nature of this task, we will extend the transition period for states to demonstrate compliance with the home and community-

based settings criteria until March 17, 2022 for settings in which a transition period applies. We anticipate that this additional three years will be helpful to states to ensure compliance activities are collaborative, transparent and timely.

CMS remains committed to providing technical assistance to states and other stakeholders in understanding regulatory provisions and developing implementation approaches that maximize the provision of Medicaid services in a manner compliant with program requirements.

If you have any questions, please contact Mike Nardone, Director, Disabled and Elderly Health Programs Group, at 410-786-7089.

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Monday, June 12, 2017 4:03 PM
To: Gerstenberger, Roy; Hamilton, Kathleen; Tierney-Ward, Megan; Courcelle, Andre; Harrigan, Emma; Omland, Laurel
Cc: Clark, Bill
Subject: HCBS Implementation Team Next Steps
Attachments: VT Milestone Template.docx; CMCS Informational Bulletin new HCBS rules May 9, 2017.pdf

Hi All,

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Agenda
June 12, 2017

1. *CMS Memo May 9, 2017*

2. *CMS Proposed Milestones and End Dates*

3. *HCBS Provider Survey – update*

4.CMS Follow Up – case management conflict of interest issue

Thank you,

Shawn

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Thursday, March 30, 2017 2:20 PM
To: Courcelle, Andre
Subject: HCBS self assessment plan

Importance: High

Hi Andre,
This is a list that Shawn sent on 3/9 for what he needs to launch the survey on Monday 4/3. Have you been able to give him any of this information yet?

- Create personalized messages (both content and look) that you would like to send to providers. SG offers customizable messages for invites, reminders, and thank yous. I can send you a template that you can modify. **As a group, we will need to determine the most efficient way to customize the look of your messages**. He needs this tomorrow.
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- **Determine survey open and close dates**. I propose Monday, April 3rd as the day that DAIL provider surveys should be sent out – and Friday, April 28th as the closing date. As far as DMH is concerned – I propose May 1st and May 31st OR June 1st and June 30th. These dates are flexible – but we need to agree on dates ahead of the Comprehensive Quality Strategy (CQS – aka Vermont's State Transition Plan) public posting next Friday, March 17th. I think 4/3/17-4/28/17 is OK. DO you?
- **Clarify a monitoring plan**. SG has numerous statistics that track message/survey delivery and completion. We need to determine how best to use the information available via the application to enhance response rates, flag concerns, and monitor any corrective actions. Thoughts on this?

Please keep in mind that these items relate to provider self-assessments only. We have an update meeting scheduled for this coming Monday, March 13th from 3:30pm-4:30pm. I would like to use some of this meeting to review this email, make some decisions, and determine next steps – including the administration of the consumer validation survey. If you would like to talk before our meeting, please feel free to email, call, or stop by.

Megan Tierney-Ward
Adult Services Division Director

March is National Nutrition Month®! *Did you know that over 20,000 older Vermonters face the threat of hunger? The Older Americans Act nutrition programs help alleviate hunger and malnutrition for millions of vulnerable elders across the country. In 2016 over 800,000 nutritious meals were delivered to the homes of older Vermonters, helping to keep them healthy and independent in their homes.*

NEW ASD Website: http://asd.vermont.gov/
NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Forkas at colleen.forkas@vermont.gov. Thank you.

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Friday, November 17, 2017 4:06 PM
To: Skaflestad, Shawn; Courcelle, Andre
Subject: Re: CMS CQS Question due Today

I think that is good. Thanks Shawn. I just took out reference to a TBI regulation because we don't have one.

Vermont agrees with the CMS determination that state TBI policies are currently non-compliant for the requirements of freedom from restraint because restraint is allowed without incorporating 42 CRF 441.301(c)(viii)(A) through (H).). The state will adjust the score contained in the TBI systemic assessment and include the updating of TBI policies as a corrective action in the corresponding TBI work plan.

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 3:53 PM
To: Tierney-Ward, Megan; Courcelle, Andre
Subject: RE: CMS CQS Question due Today

Megan,

Are you comfortable with the following response?

Vermont agrees with the CMS determination that state TBI policies and regulations are currently non-compliant for the requirements of freedom from restraint because restraint is allowed without incorporating 42 CRF 441.301(c)(viii)(A) through (H).). The state will adjust the score contained in the TBI systemic assessment and include the updating of TBI policies as a corrective action in the corresponding TBI work plan.

Shawn

From: Suzanne Santarcangelo [mailto:ssantarcangelo@phpg.com]
Sent: Friday, November 17, 2017 3:29 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: RE: CMS CQS Question due Today

Hi All,

The residential care licensing regulations do not appear to allow for the use of restraint as part of an on-going treatment plan:

- Participant Rights Section 6.12 – indicates *"the resident has the right to be free from mental, verbal or physical abuse, neglect and exploitation. Residents shall also be free from restraint as described in 5.14."*
- Section 5.14 indicates that *"mechanical restraint may only be used in and emergency to prevent harm to self or others and shall not be used as any on-going form of treatment."* 5.14(e) also states residents have a right to be free from chemical and mechanical restraint. There are also requirements that a physician be consulted, and it can only be continued with specific physician orders. The Provider must inform DAIL of any instance and complete a reassessment (within 72 hours) of the person needs in consultation with the physician, resident and resident's legal rep.

Vermont could be considered more stringent because it says restraint is not allowed as part of a plan of care at all; or it could be considered a 'loophole' because it allows for clinical restraints in unplanned emergencies/threats of harm (similar to hospital rules). I believe that CMS is saying that the use of restraint in an emergency situation must be outlined in the individuals person-centered plan as a 'modification'. It would then be allowable and subject to the CMS review standards in *42 CFR 441.301(c)(viii)(A) through (H).)*

You could change the score to "partial" and address it in your remediation plan and TBI policies such that TBI program participants would have emergency protocols in their plan that clearly noted when/if restraint was OK. Conversely, you could assert it is never OK as part of an active treatment plan and will continue to be treated as a reportable incident.

I recall some discussion about adopting DDS-like guidelines around applied behavioral analysis and interventions for TBI but am not aware of the outcome.

Suzanne
Senior Associate
Pacific Health Policy Group, (PHPG)
p. (802) 882-8228

From: Skaflestad, Shawn [mailto:Shawn.Skaflestad@vermont.gov]
Sent: Friday, November 17, 2017 12:56 PM
To: Suzanne Santarcangelo <ssantarcangelo@phpg.com>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: RE: CMS CQS Question due Today

Thanks Suzanne! #2 seems risky to me – but if we have a solid response – I am happy to include it!

Shawn

From: Suzanne Santarcangelo [mailto:ssantarcangelo@phpg.com]
Sent: Friday, November 17, 2017 12:54 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: RE: CMS CQS Question due Today

Shawn – I will not be able to review the report and background materials until about 2 or 3pm today – however I suspect that the licensing regulations may discuss restraint, it is also possible that we got the info (that Megan notes below) from interview with Andre – As I recall, at the time Andre (the State) was closely involved in and approved every service plan and thus would know if restraint was being used... I will look at my notes as soon as I am free, however #2 may be an option today.

Suzanne
Senior Associate
Pacific Health Policy Group, (PHPG)
p. (802) 882-8228

From: Skaflestad, Shawn [mailto:Shawn.Skaflestad@vermont.gov]
Sent: Friday, November 17, 2017 12:47 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Suzanne Santarcangelo <ssantarcangelo@phpg.com>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: RE: CMS CQS Question due Today

As far as today's submission is concerned – I see the following options:

1. Agree w/CMS finding – and suggest that we are going to modify the *statutory provisions, regulations, and policy documents* in question;
2. Disagree w/CMS finding – and suggest how they have misinterpreted the references we provided; OR
3. Request a meeting w/CMS so they can clarify their comment.

Of the options listed above – only #1 and #3 can be accomplished by cob today.

Shawn

From: Tierney-Ward, Megan
Sent: Friday, November 17, 2017 10:04 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Suzanne Santarcangelo (ssantarcangelo@phpg.com) <ssantarcangelo@phpg.com>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: Re: CMS CQS Question due Today

Yikes. I don't know how to help. Restraints are not genetically allowed. Only with a specific care plan. They will always be considered a "modification" according to the hcbs rules.

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From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 9:59:46 AM
To: Suzanne Santarcangelo (ssantarcangelo@phpg.com); Tierney-Ward, Megan; Courcelle, Andre
Subject: CMS CQS Question due Today

Hi Suzanne, et al.,

Please take a look at the CMS comment below. I believe that CMS is disagreeing with scoring in the TBI Systemic Assessment (bottom of p.11/top of p.12).

For the TBI waiver, the state assessed its state policies and regulations as compliant with the federal requirement that a setting ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint. CMS found that the statutory provisions, and some of the regulations and policy documents cited by the state are compliant with the requirement to ensure rights to privacy, dignity, and respect and freedom from coercion but non-compliant for the requirement of freedom from restraint because restraint is allowed without incorporating 42 CFR 441.301(c)(viii)(A) through (H).).

Sorry to pick this up so late – but we are going to need a draft response that addresses this issue before the end of the day so I would appreciate any/all thoughts.

Shawn

Kennedy, Alice

From: Courcelle, Andre
Sent: Friday, November 17, 2017 1:13 PM
To: Tierney-Ward, Megan
Subject: RE: CMS CQS Response due today

We will make the changes as Megan has stated. I will need time to research the section CMS referenced in their comments.

Andre' R Courcelle
Quality & Provider Relations Program Director
Adult Services Division
Department of Disabilities, Aging and Independent Living
280 State Drive HC-2 South
Waterbury, VT 05671-2070
Office: 802 786-2516
Fax: 802 786-5055
andre.courcelle@vermont.gov

From: Tierney-Ward, Megan
Sent: Friday, November 17, 2017 12:57 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: Re: CMS CQS Response due today

Like CFC we will incorporate the hcbs "modifications" requirement language into the TBI standards and follow those standards. Assurance will be built into the TBI quality review process, like CFC.

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From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 12:53:05 PM
To: Tierney-Ward, Megan; Courcelle, Andre
Subject: RE: CMS CQS Response due today

As far as today's submission is concerned, I see the following two options:

1. Tell CMS that the work plan has been modified to include *how the state will ensure that any use of restrictive interventions will be handled and documented via the person-centered planning process, following the criteria in 42 CFR 441.301(c)(viii)(A) through (H).*
2. Request a meeting w/CMS so they can clarify their comment.

If we choose #1 – I am not sure what details would be added to the work plan.

Shawn

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 10:17 AM

To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: CMS CQS Response due today

Hi Megan and Andre,

According to our TBI systemic assessment – Vermont regulations/policies are silent on all of the modifications (A-H) listed under

14. Modification to HCBS Settings Requirements: Restrictions of rights and/or restrictive practices are not contemplated in program guidance (settings requirements)

In our workplan we said we would do a bunch of things to bring our regulations/policies in line with those of the Feds. After looking over the TBI work plan – CMS made the following comment:

> *Please clarify how the state will ensure that any use of restrictive interventions will be handled and documented via the person-centered planning process, following the criteria in 42 CFR 441.301(c)(viii)(A) through (H).*

Any suggestions re: how we might reply to this comment?

Shawn

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Thursday, May 11, 2017 9:14 AM
To: Tierney-Ward, Megan; Gerstenberger, Roy
Cc: Courcelle, Andre; Hill, Bard
Subject: RE: CMS Extends Settings Rule Deadline to 2022
Attachments: VT Milestone Template.docx

If I am interpreting this correctly – we have until March 17, 2019 (original compliance date) to get a final approval for our CQS/STP. Full compliance is not expected until March 17, 2022.

Any thoughts re: how this new information impacts the attached draft Milestone Template proposed by CMS last month?

Shawn

From: Tierney-Ward, Megan
Sent: Tuesday, May 09, 2017 2:25 PM
To: Gerstenberger, Roy
Cc: Courcelle, Andre ; Skaflestad, Shawn ; Hill, Bard
Subject: Re: CMS Extends Settings Rule Deadline to 2022

Thank you Roy!

Megan

Sent from my iPhone

On May 9, 2017, at 11:53 AM, Gerstenberger, Roy <Roy.Gerstenberger@vermont.gov> wrote:

> Hello Everyone,
>
> This morning, CMS released an informational bulletin noting that states will have an additional three years (until 2022) to comply with the settings requirements of the HCBS regulations. CMS notes that states must still work to gain approval for their Statewide Transition Plans by 2019, but that additional time is being provided to achieve compliance in recognition of the complex work necessary.
>
> ROY GERSTENBERGER, Director
> *Lisa Parro, Executive Assistant: lisa.parro@vermont.gov*
> Developmental Disabilities Services Division
> Department of Disabilities, Aging and Independent Living
> 280 State Drive, HC 2 South
> Waterbury, VT 05671-2030
> 802-241-0295 office/802-798-2000 cell
> https://www.facebook.com/vtddsd/

Milestone Template -- DRAFT

Background

In order to collect consistent information on the implementation of the HCB Settings regulations and Statewide Transition Plan (STP), CMS has identified a standard set of milestones to track across states. Since each state is different, the milestone must align with the Statewide Transition Plan (STP) evidence. States may need to provide more than one date for a particular milestone because the states will report completion in percentages, such as 25% or 50% complete. This approach will provide CMS insight in regards to the status of completion pertaining to particular milestones.

Instructions and Reminders

The following milestone list provides CMS the opportunity to track progress in implementation of each state's STP. Please provide dates for each milestone and where possible, the corresponding page number in the STP. Per the SOTA call on February 4, 2016, the state will receive email reminders 30 days prior to the due date of each milestone input into the system and when milestones are past due. States will also have the opportunity to update CMS on the milestones below through the HCB Settings website.

- All dates included in the template below should also align with the STP.
- The red italic text provides additional details related to each milestone. Please reach out to CMS with specific questions.
- Some milestones may have the same proposed due dates-as these steps may be undertaken simultaneously.
- States are encouraged to provide additional details on each milestone in the description column below. The description field will be transferred and available for viewing on the HCB Settings Website.

This template was completed using the June 10, 2016 STP submission.

Milestone	Description	Proposed End Date	STP Page No.
Systemic Assessment and Remediation			
Completion of systemic assessment *[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]*	Complete crosswalk of state regulations compared to new federal HCBS requirements (scored as alignment, partial alignment, silent, or non-compliant)	Completed (12/31/2015)	HCBS DS Timeline; p. 7 (STP)
Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.		**Please complete**	
Implementation of new rules and regulations: 50% complete *[The date when at least 50% of all rules, regulations, and statutes identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]*		**Please complete**	
Implementation of new rules and regulations: 100% complete *[The date when all rules, regulations, and statutes (100%) identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]*		**Please complete**	
Site-specific Assessments			

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Completion of site-specific assessment *[The date when the overall completion of the site-specific assessment, including review of all settings and the validation of assessment results.]*	Determine settings ability to accommodate new HCBS requirements (with scoring outcomes/results) **CFC, DS, and TBI** **SED and CRT**	 Completed 6/30/2016 3/31/2017	HCBS DS Timeline
Incorporate results of settings analysis into final version of the STP and release for public comment	Share site specific settings assessment and validation plan with external stakeholders **CFC, DS, and TBI** **SED and CRT**	 Completed (7/1/2016) 3/31/2017	HCBS DS Timeline
Submit final STP to CMS		**Please complete**	
Site-specific Remediation[1]			
Completion of residential provider remediation: 25% *[The date when approximately 25% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*	Identify remedial action steps (i. e, corrective action plan) for settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment. **CFC, DS, and TBI** **SED and CRT**	 Completed (9/30/2016) 9/30/2017	HCBS DS Timeline
Completion of residential provider remediation: 50%		**Please complete**	

Commented [MM1]: The HCBS DS Timeline does not distinguish between residential and nonresidential provider remediation; therefore these milestones are listed under both.

[The date when approximately 50% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]			
Completion of residential provider remediation: 75% *[The date when approximately 75% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of residential provider remediation: 100% *[The date when all residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 25% *[The date when approximately 25% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*	Identify remedial action steps (i. e, corrective action plan) for settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment. **CFC, DS, and TBI** **SED and CRT**	 Completed (9/30/2016) 9/30/2017	HCBS DS Timeline

Commented [MM2]: The HCBS DS Timeline does not distinguish between residential and nonresidential provider remediation; therefore these milestones are listed under both.

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Completion of nonresidential provider remediation: 50% *[The date when approximately 50% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 75% *[The date when approximately 75% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Completion of nonresidential provider remediation: 100% *[The date when all nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]*		**Please complete**	
Identification of settings that will not remain in the HCBS System *[The date those settings that are considered institutional or are not willing to remediate will be identified for removal from the HCBS System]*		**Please complete**	
Heightened Scrutiny[2]			
Identification of settings that overcome the presumption and will be	Identify process and settings presented for heightened scrutiny – if necessary.	Complete (Please complete)	HCBS DS Timeline

Commented [MM3]: Please provide a completion date.

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submitted for heightened scrutiny and notification to provider			
Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		**Please complete**	
Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment		**Please complete**	
Submit STP with Heightened Scrutiny information to CMS for review		**Please complete**	
Relocation			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 25% *[The date when members, guardians, case managers, etc. in approximately 25% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 50%		**Please complete**	

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[The date when members, guardians, case managers, etc. in approximately 50% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 75% *[The date when members, guardians, case managers, etc. in approximately 75% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 100% *[The date when members, guardians, case managers, etc. in all providers have been notified that relocation is required. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 25%	Identify VT plan to relocate consumers – if necessary. Currently	**Please complete**	HCBS DS Timeline

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[The date when beneficiaries in approximately 25% of providers have been relocated. Please provide additional details on settings in the description.]	in CQS – but may need to be modified as we learn more.		
Complete beneficiary relocation across all providers: 50% *[The date when beneficiaries in approximately 50% of providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 75% *[The date when beneficiaries in approximately 75% of providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	
Complete beneficiary relocation across all providers: 100% *[The date when beneficiaries in all providers have been relocated. Please provide additional details on settings in the description.]*		**Please complete**	

[1]This section includes only those providers where remediation was required.
[2]The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

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Quarterly reporting: Per the initial and final approval STP letter, CMS requests quarterly updates on the HS progress. The following milestones will provide a system to monitor the submission of these reports.

Milestone	Description	Proposed End Date	STP Page No.
Quarterly progress reporting updates			
Quarterly progress update *[First quarter after initial and/or final approval.]*			
Quarterly progress update *[Second quarter after initial and/or final approval.]*			
Quarterly progress update *[Third quarter after initial and/or final approval.]*			
Quarterly progress update *[Fourth quarter after initial and/or final approval.]*			
Quarterly progress update *[Fifth quarter after initial and/or final approval.]*			
Quarterly progress update *[Sixth quarter after initial and/or final approval.]*			
Quarterly progress update *[Seventh quarter after initial and/or final approval.]*			

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Kennedy, Alice

From: Hill, Bard
Sent: Monday, July 24, 2017 5:17 PM
To: Skaflestad, Shawn; Tierney-Ward, Megan; Courcelle, Andre; Gerstenberger, Roy; Harrigan, Emma; Omland, Laurel; Clark, Bill; McFadden, Clare
Cc: Hickman, Selina; Carmichael, Erin
Subject: RE: CQS Public Comment and Draft State Responses
Attachments: CQS Pubic Hearing Comments with draft State Responses July 24 2017.bh.docx

Hi-
Not sure if the additions (using track changes) are helpful...
Thanks Shawn.
Bard

From: Skaflestad, Shawn
Sent: Monday, July 24, 2017 3:07 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>; Gerstenberger, Roy <Roy.Gerstenberger@vermont.gov>; Harrigan, Emma <Emma.Harrigan@vermont.gov>; Omland, Laurel <Laurel.Omland@vermont.gov>; Hill, Bard <Bard.Hill@vermont.gov>; Clark, Bill <Bill.Clark@vermont.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>; Carmichael, Erin <Erin.Carmichael@vermont.gov>
Subject: CQS Public Comment and Draft State Responses

Hi All,

As you may recall, a formal public hearing for the attached Comprehensive Quality Strategy (CQS)/State Transition Plan (STP) was held on Thursday, April 21, 2017 from 1pm - 2pm at the Waterbury State Office Complex (WSOC). While no individuals from the community attended the hearing – I did receive three pieces of written feedback during the public comment period. I have attached a Word file that contains a summary of the public comments from these documents – along with draft State responses. As you will notice – not all comments have responses.

I am asking that you edit my draft responses – as well as suggest language for those comments w/o responses - by cob this Friday, July 28th. Once this document is complete – I will modify the CQS/STP accordingly – and submit it to CMS for review. Please feel free to contact me with any questions.

Thank you,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
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Waterbury, VT 05671-1000
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Fax: 802-241-0450

Find out how Vermonters are doing with the AHS Results Scorecard.
(Access through Internet Explorer 10, Firefox, or Google Chrome).

Vermont Agency of Human Services (AHS) – Global Commitment to Health Comprehensive Quality Strategy (CQS)/State Transition Plan (STP)
Summary of Public Comment

Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS)/State Transition Plan (STP) is reviewed publicly and that public input is incorporated into the final version. Public meeting notices were advertised in the *Burlington Free Press* and posted on multiple state websites. In addition to the *Burlington Free Press* – the notice was sent to Agency of Human Services District Offices, the Medicaid and Exchange Advisory Board, Disability Aging and Independent Living Advisory Board, and the Developmental Services State Program Standing Committee. In addition, the public hearing date was published in the Agency of Administration Department of Libraries public meeting calendar. A formal public hearing was held on Thursday, April 21, 2017 from 1pm - 2pm at Waterbury State Office Complex (WSOC) in Waterbury Vermont. Public input received included:

- No individuals attended the public meeting.
- Written comment received during the 30-day public comment period by three (3) organizations/individuals.

After reviewing the written comment documents received, the state identified the comments in the table below. In an attempt to thoroughly capture stakeholder feedback - the state chose to break apart some commenter's statements into multiple comments. Also, to enhance readability, the state created headers for similar comments. Please note that comments are not further sorted by individual or organization – so multiple comments under the same header might (and in many cases do) belong to the same individual or organization. All public comment reference documents will be submitted to CMS in their entirety along with the CQS.

Public Comment Received on VT Global Commitment to Health Comprehensive Quality Strategy & State Responses

Outreach & Stakeholder Involvement

Public Comment	State Response
In conversations with people with developmental disabilities I am hearing that they have not been taken seriously nor has there been sufficient time for them to provide input to this document. We recommend that you extend the period for public input and actually solicit consumer input more directly from people with disabilities	Vermont is committed to ensuring that our statewide CQS is reviewed publicly and that public input is incorporated into the final strategy. A summary of public comments and agency response will be made available on August 25, 2017. In terms of compliance with HCBS rules, each specialized program including Developmental Disabilities Services will include consumers and stakeholders in its own HCBS Compliance Plan.
People with disabilities and their families need to be at the table when assessing how the HCBS we receive are in compliance with federal requirements. What is your plan for seeking out and including our opinions?	It is the state's expectation that stakeholders will be invited to participate in all phases of CQS review and in identifying areas for further action. In terms of compliance with HCBS rules, each specialized program including Developmental Disabilities Services will include consumers and stakeholders in its own HCBS Compliance Plan.
To date we feel that there has not been adequate involvement of people with disabilities and their families when you developed your CQS.	The CQS includes a description of the public input process, with a summary of public comments. Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii). -In terms of compliance with HCBS rules, each specialized program including Developmental Disabilities Services will include consumers and stakeholders in its own HCBS Compliance Plan.

Person Centered Planning & Conflict Free Case Management

The document does not specifically address the issue of conflict free case management.	Vermont's rules and statutes currently require person-centered planning for all populations. The person-centered planning provisions of the HCBS rules at 42 CFR§441.301(c)(1), (2) and (3) became effective on March 17, 2014. These requirements are not subject to a phase in or transition period. Compliance with these requirements is being addressed by the ongoing monitoring and compliance requirements of

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HCBS CQS July 2018 000156

	the CQS. Each specialized program will address the conflict free case management element in its own HCBS Compliance Plan.
The proposed CQS fails to address many aspects of the person-centered planning provisions of the HCBS rules at 42 CFR §441.301(c)(1), (2) and (3) which became effective on March 17, 2014.	Vermont is required to comply with the Home and Community Based Service (HCBS) regulations found at 42 CFR §441.301(c)(1), (2) and (3) pertaining to Person-Centered Planning, 42 CFR§441.301(c)(4) and (5) pertaining to Home and Community Based Settings, and 42 CFR §441.301(c)(6) pertaining to a Transition Plan for coming into compliance with Home and Community Based Settings requirements. Each specialized program will address the person-centered planning provisions in its own HCBS Compliance Plan.
1) Providers of HCBS for the individual, or those who have an interest in the individual or are employed by a provider of HCBS for the individual do not provide case management or develop the individual's person-centered plan. 42 CFR §441.301(c)(l)(vi);	
2) The setting in which the individual resides is chosen by the individual. 42 CFR §441.301(c)(2)(i);	
3) Natural unpaid supports are provided voluntarily to the individual in lieu of ... HCBS waiver services and supports. 42 CFR §44I.301(c)(2)(v).	
The proposed CQS fails to include information on the extent of Vermont's compliance with the person-centered planning rule and to describe specific steps it will take to come into compliance where necessary.	Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.

Ongoing Monitoring & Oversight

Vermont programs that provide support, intervention, care for people with DD must have oversight	Compliance with the new requirements is addressed in the ongoing monitoring and compliance sections of the CQS. Each individual program must ensure that the key concepts of these sections are implemented. Under Vermont statute, the Department of Disabilities Aging and Independent Living provides oversight to Vermont programs that provide services to people with ID/DD.

Site Specific Assessment & Validation

HCBS CQS July 2018 000157

It is not acceptable that agencies do not go through a comprehensive review including interviews/home visits with people with DD. This review must include interviewing recipients of services and assessing their well-being.	The State is using a survey to assess specific settings in which HCBS are provided to determine whether they are in compliance with the new HCBS setting rules. The survey is intended to be administered as a provider self-assessment. Results of this survey will help determine remedial actions that must be taken by the state and providers to bring the specific settings into compliance. A consumer survey is being used to validate the provider self-assessment results. The information captured via the survey is linked to a specific setting in which HCBS are provided. Each specialized program including Developmental Disabilities will complete an assessment/review process in its own HCBS Compliance Plan.

Site Specific Remediation

Despite the fact that Vermont is considered an "Inclusion" State there are many aspects of the current systems that reflect an institutionalization bias. There are group homes that have been constructed to have various doors or walls to indicate separate residency; however, they are basically ICF MR and should be dismantled.	The State is using a survey to assess specific settings in which HCBS are provided to determine whether they are in compliance with the new HCBS setting rules. The survey is intended to be administered as a provider self-assessment. Results of this survey will help determine remedial actions that must be taken by the state and providers to bring the specific settings into compliance. Please see the CQS Relocation Plan and Process Section for more detail re: settings that are not able or willing to comply with the new HCBS regulations. Each specialized program including Developmental Disabilities will complete an assessment/review process in its own HCBS Compliance Plan

General Comments

The CQS does not describe how the state will ensure that the person receiving services will be supported to lead the process of making his/her person-centered service plan.	Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.
The CQS does not outline how you plan to ensure that the setting a person lives in is truly chosen by the person.	Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.
The CQS fails to outline how you will require service providers to foster the development of natural supports in a person's life.	Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.

HCBS CQS July 2018 000158

Table 9 describes HCBS regulatory requirements related to HCBS settings and "Examples of Acceptable Practice." While Table 9 does include many of the regulatory requirements found in the HCBS rules, it fails to include the "setting options" requirement found at 42 CFR §44I.301(c)(4)(ii).	Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.
Table 9 fails to include "Examples of Best Practices" related to the aforementioned requirement.	Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.

HCBS CQS July 2018 000159

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Monday, April 10, 2017 3:16 PM
To: Tierney-Ward, Megan; Gerstenberger, Roy; Courcelle, Andre; Harrigan, Emma; Omland, Laurel
Cc: Hamilton, Kathleen; Clark, Bill
Subject: RE: HCBS CQS/STP Work Plan Milestones
Attachments: Price-Verma Letter to States - 3-14-17.pdf

I believe that this letter was mentioned during our last meeting (specifically the first paragraph on top of page 3). While I don't have any updates – I wanted to make sure folks were aware of the communication.

Shawn

From: Skaflestad, Shawn
Sent: Monday, April 10, 2017 12:25 PM
To: Tierney-Ward, Megan ; Gerstenberger, Roy ; Courcelle, Andre ; Harrigan, Emma ; Omland, Laurel
Cc: Hamilton, Kathleen ; Clark, Bill
Subject: RE: HCBS CQS/STP Work Plan Milestones

Hi Everyone,

Below are some of the items I would like to discuss this afternoon:

- Sender and Subject Line of survey email;
- Link in introductory email (user-friendly and hyperlink);
- Use of http vs https protocol (security);
- Multiple responses from one contact (functionality and messaging);
- Contact list; and
- Communicating w/providers

Kathy has been fielding comments, concerns, and questions from the DS providers – so she might have some other things to add as well.

Best,

Shawn

-----Original Appointment-----
From: Hurlburt, Laurie **On Behalf Of** Skaflestad, Shawn
Sent: Friday, May 13, 2016 11:49 AM
To: Skaflestad, Shawn; Tierney-Ward, Megan; Gerstenberger, Roy; Courcelle, Andre; Harrigan, Emma; Omland, Laurel; Clark, Bill; Hawes, Emily
Cc: Hamilton, Kathleen; Reed, Frank
Subject: HCBS CQS/STP Work Plan Milestones
When: Monday, April 10, 2017 3:30 PM-4:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Spruce 8 (DAIL)

Hi All,

I am extending our monthly HCBS CQS/STP Milestone meeting through June of 2017. Please note that I changed the location of this meeting to Spruce 8 (2nd floor of the Historic Core South – near DAIL). Thank you for your continued involvement.

Shawn

Conference Call Information:
Dial-In Number: 1-877-273-4202
Conference Room ID: 1262904

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Dear Governor:

We write to you to affirm our partnership in improving Medicaid and the lives of those it serves. Medicaid is a safety net program that provides life-saving medical care to millions of Americans facing some of the most challenging health circumstances. In addressing the diversity and complexity of Medicaid recipients, we have a duty to ensure the highest level of quality, accessibility, and choices for Americans who rely on the program. We also have an obligation to taxpayers to make sure Medicaid operates in a way that best serves the most vulnerable populations.

Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable.

Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid's challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.

As we break down the barriers to support state initiatives aimed at continuously improving the health outcomes for their Medicaid population, we remain committed to certain mechanisms, which ensure state accountability for the outcomes produced by the Medicaid program. For example, budget neutrality for waivers and demonstration projects remains an important policy for protecting the long-term sustainability of the program for states and the federal government,

and state waiver and demonstration requests will continue to be reviewed on a case-by-case basis. Similarly, reasonable public input processes and transparency guidelines provide states an opportunity to consider the views of Medicaid enrollees and stakeholders and gather input that may support continuous improvement of the program.

Some of the key areas where we will improve collaboration with states and move towards more effective program management are described below.

Improve Federal and State Program Management
The Centers for Medicare & Medicaid Services (CMS) is committed to engaging with states in a bilateral process to make the State Plan Amendment approval process more transparent, efficient, and less burdensome. Additionally, we aim to improve the process and speed to facilitate expedited—or "fast-track"—approval of waiver and demonstration project extensions. We also endeavor to be more consistent in evaluating and incorporating state requests for specific waivers and demonstration project approaches that have already received approval in another state. Finally, we plan to conduct a full review of managed care regulations in order to prioritize beneficiary outcomes and state priorities.

Support Innovative Approaches to Increase Employment and Community Engagement
Today, we reaffirm the agency's commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.

Align Medicaid and Private Insurance Policies for Non-Disabled Adults
States may also consider creating greater alignment between Medicaid's design and benefit structure with common features of commercial health insurance, to help working age, non-pregnant, non-disabled adults prepare for private coverage. These state-led reforms could include, as allowed by law:

- Alternative benefit plan designs and cost-sharing models, including consumer-directed health care with Health Savings Account-like features, for individuals at all income levels;
- Facilitating enrollment in affordable employer-sponsored health insurance options;
- Reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations;
- Initiatives designed to break down the barriers that prevent families from being together on the same plan;
- Waivers of non-emergency transportation benefit requirements;
- Expanded options to design emergency room copayments to encourage the use of primary and other non-emergency providers for non-emergency medical care; and
- Waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage.

Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation

CMS has worked with our state partners and other stakeholders to implement provisions of the final regulation defining a home and community-based setting. In recognition of the significance of the reform efforts underway, CMS will work toward providing additional time for states to comply with the January 16, 2014, Home and Community-Based Services (HCBS) rule. Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings.

Provide States with More Tools to Address the Opioid Epidemic

We are committed to ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities. In recognition of the urgent need to improve access to comprehensive substance abuse treatment, we will continue to work with states to improve care for individuals struggling with addiction under their Medicaid state plans and through the Medicaid Innovation Accelerator Program to improve their substance abuse treatment delivery systems. In addition, under recent regulatory changes, states may now make managed care capitation payments for individuals with Institutions for Mental Disease stays of 15 days or less within a month. We will continue to explore additional opportunities for states to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities. We look forward to building upon initial efforts, including previous collaborations amongst the states.

We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our shared goals of providing high quality, sustainable, health care to those who need it most.

Yours truly,

Thomas E. Price, M.D.
Secretary

Seema Verma, MPH
CMS Administrator

Kennedy, Alice

From: Courcelle, Andre
Sent: Thursday, March 30, 2017 2:37 PM
To: Tierney-Ward, Megan
Subject: RE: HCBS self assessment plan

Hi Megan,
If you want to take a stab at the message that would be great. I have responded to your questions below in blue. I'll get you the updated table this afternoon.
Andre

Andre 'R Courcelle
Quality & Provider Relations Program Director
Adult Services Division
Department of Disabilities, Aging and Independent Living
280 State Drive HC-2 South
Waterbury, VT 05671-2070
Office: 802 786-2516
Fax: 802 786-5055
andre.courcelle@vermont.gov

From: Tierney-Ward, Megan
Sent: Thursday, March 30, 2017 2:20 PM
To: Courcelle, Andre
Subject: HCBS self assessment plan
Importance: High

Hi Andre,
This is a list that Shawn sent on 3/9 for what he needs to launch the survey on Monday 4/3. Have you been able to give him any of this information yet?

- Create personalized messages (both content and look) that you would like to send to providers. SG offers customizable messages for invites, reminders, and thank yous. I can send you a template that you can modify. **As a group, we will need to determine the most efficient way to customize the look of your messages**. He needs this tomorrow. I just need to change some of the contact information I will update and get it to you by the end of the day
- Upload a spreadsheet containing provider contact information. In order to do this, **I will need a spreadsheet from you with provider contact information (specifically emails)**. To date, I have set up 3 DAIL email campaigns (i.e., CFC providers, DS providers, and TBI providers). As a result, I will need a spreadsheet with provider contact information for each. I have also set up 3 DMH email campaigns (i.e., CRT providers, EFT providers, and EFT Parents/Guardians). Similar to DAIL – each will need a spreadsheet with contact information. I set up the email campaigns – so if these don't make sense – we can make adjustments. I just emailed you an excel sheet that just needs some missing TBI provider information. We will be providing the contact information for the active providers only I'm on it
- **Determine survey open and close dates**. I propose Monday, April 3rd as the day that DAIL provider surveys should be sent out – and Friday, April 28th as the closing date. As far as DMH is concerned – I propose May 1st and May 31st OR June 1st and June 30th. These dates are flexible – but we need to agree on dates ahead of the

Comprehensive Quality Strategy (CQS – aka Vermont's State Transition Plan) public posting next Friday, March 17th. I think 4/3/17-4/28/17 is OK. DO you? These dates should work

- **Clarify a monitoring plan**. SG has numerous statistics that track message/survey delivery and completion. We need to determine how best to use the information available via the application to enhance response rates, flag concerns, and monitor any corrective actions. Thoughts on this? A follow-up blast email later next week may help to improve the response rate. The changes we have made and are making to our provider manuals will help guide the response to areas of concern and corrective actions, (this part would be in the next step).

Please keep in mind that these items relate to provider self-assessments only. We have an update meeting scheduled for this coming Monday, March 13th from 3:30pm-4:30pm. I would like to use some of this meeting to review this email, make some decisions, and determine next steps – including the administration of the consumer validation survey. If you would like to talk before our meeting, please feel free to email, call, or stop by.

Megan Tierney-Ward
Adult Services Division Director

March is National Nutrition Month®! *Did you know that over 20,000 older Vermonters face the threat of hunger? The Older Americans Act nutrition programs help alleviate hunger and malnutrition for millions of vulnerable elders across the country. In 2016 over 800,000 nutritious meals were delivered to the homes of older Vermonters, helping to keep them healthy and independent in their homes.*

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Forkas at colleen.forkas@vermont.gov. Thank you.

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Thursday, March 23, 2017 3:08 PM
To: Hill, Bard; Parker, Lindsay; Gerstenberger, Roy
Cc: George, Camille; Skaflestad, Shawn; Hickman, Selina; Courcelle, Andre
Subject: RE: Timely questions - HCBS fed reg
Attachments: Price-Verma Letter to States - 3-14-17.pdf

This is interesting. Though I believe our timeline is looking good for CFC on the HCBS rules compliance, we have not yet received the guidance we requested from CMS regarding case management and conflict of interest (unless we did while I was on vacation... Selina?). So more time is never a bad thing if we are faced with a potential big shift in how we deliver case management. Perhaps the statement "we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings" is a sign that CMS will be more flexible within the rules???

Megan

From: Hill, Bard
Sent: Thursday, March 23, 2017 12:28 PM
To: Parker, Lindsay ; Gerstenberger, Roy ; Tierney-Ward, Megan
Cc: George, Camille
Subject: Re: Timely questions - HCBS fed reg

I defer to roy and Megan in DAIL
Not sure who the dmh lead is

Sent from my iPhone

On Mar 23, 2017, at 12:25 PM, Parker, Lindsay <Lindsay.Parker@vermont.gov> wrote:

> Sorry Bard sitting in ACA meeting.
>
> Is it fair to say VT is on track to come into compliance by 2019?
>
> ---
> **Lindsay Parker**
> Agency of Human Services
> [p] 802-578-9427
>
> ---
>
> **From:** Hill, Bard
> **Sent:** Thursday, March 23, 2017 12:24 PM
> **To:** Parker, Lindsay <Lindsay.Parker@vermont.gov>
> **Cc:** George, Camille <Camille.George@vermont.gov>
> **Subject:** Re: Timely questions - HCBS fed reg
>
> Hi
> Both DAIL and dmh are working on a

hcbs rules, as d scribed in the gc cqs. Roy is lead for dds and Megan for cfc and tbi
Bard

Sent from my iPhone

On Mar 23, 2017, at 11:53 AM, Parker, Lindsay <Lindsay.Parker@vermont.gov> wrote:

> Hi Bard and Camille,
>
> Am hoping you can let me know if the fed reg below is one DAIL has been working on and where VT is with compliance? (attached is Verma-Price letter for context).
>
> Am asking so I can provide update to Cory asap (he has reporter coming in for ACA repeal questions).
>
> Thanks!

Lindsay Parker, MPH
Health Access Policy & Planning Chief
Medicaid Policy, Agency of Human Services
280 State Drive, Building E-313
Waterbury, VT 05671
[p] 802-578-9427 | [f] 802-871-3001
[e] lindsay.parker@vermont.gov

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Dear Governor:

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Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

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As we break down the barriers to support state initiatives aimed at continuously improving the health outcomes for their Medicaid population, we remain committed to certain mechanisms, which ensure state accountability for the outcomes produced by the Medicaid program. For example, budget neutrality for waivers and demonstration projects remains an important policy for protecting the long-term sustainability of the program for states and the federal government,

and state waiver and demonstration requests will continue to be reviewed on a case-by-case basis. Similarly, reasonable public input processes and transparency guidelines provide states an opportunity to consider the views of Medicaid enrollees and stakeholders and gather input that may support continuous improvement of the program.

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- Reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations;
- Initiatives designed to break down the barriers that prevent families from being together on the same plan;
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- Expanded options to design emergency room copayments to encourage the use of primary and other non-emergency providers for non-emergency medical care; and
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We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our shared goals of providing high quality, sustainable, health care to those who need it most.

Yours truly,

Thomas E. Price, M.D.
Secretary

Seema Verma, MPH
CMS Administrator

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Thursday, December 07, 2017 1:33 PM
To: Tierney-Ward, Megan; Courcelle, Andre; McFadden, Clare; Harrigan, Emma; Omland, Laurel; Reed, Frank; Clark, Bill
Cc: Hutt, Monica; Bailey, Melissa; Hickman, Selina; Mohlman, Mary Kate; Gustafson, Cory
Subject: Thank you for your hard work!
Attachments: VT Initial Approval.pdf

Megan, Andre, Clare, Emma, Frank, Laurel, and Bill,

Congratulations! Please see the attached correspondence from CMS indicating that Vermont has received Initial Approval of its CQS/STP. I really appreciate the effort you have given to this project. Your contributions as a member of Vermont's HCBS Implementation team is directly responsible for this outcome. I look forward to continuing to work with you on the next iteration of this document and obtaining final approval.

Thanks again for all your time, energy, and effort!

Shawn

From: Loehr, Jessica S. (CMS/CMCS) [mailto:Jessica.Loehr@cms.hhs.gov]
Sent: Thursday, December 07, 2017 10:14 AM
To: Gustafson, Cory <Cory.Gustafson@vermont.gov>
Cc: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Hickman, Selina <Selina.Hickman@vermont.gov>; Francis, Crystal (CMS/CMCHO) <Crystal.Francis@cms.hhs.gov>; MacKenzie, Michele (CMS/CMCS) <Michele.MacKenzie@cms.hhs.gov>; Lowe, Serena (ACL) <Serena.Lowe@acl.hhs.gov>; Hill, Amanda C. (CMS/CMCS) <Amanda.Hill@cms.hhs.gov>; Beasley, Michelle (CMS/CMCHO) <Michelle.Beasley@cms.hhs.gov>; Failla, George P. (CMS/CMCS) <George.Failla@cms.hhs.gov>; Lollar, Ralph F. (CMS/CMCS) <Ralph.Lollar@cms.hhs.gov>; Cummins, Susan K. (CMS/CMCHO) <Susan.Cummins@cms.hhs.gov>; Christin Diehl <CDiehl@neweditions.net>; Laura Nuss <LNuss@neweditions.net>
Subject: Vermont STP Initial Approval Letter

Mr. Gustafson,

I have attached a scanned copy of a letter granting initial approval to the Vermont HCBS Statewide Transition Plan. The hard copy of this letter has also been sent via US Mail. The CMS STP team thanks you and your team for your continued efforts to address the HCBS Settings Rule through the Statewide Transition Plan process. It has been a pleasure working with Vermont and I look forward to the continued collaboration to come. If you have any questions or concerns please do not hesitate to contact me at the information below.

Thank you,

Jessica Loehr
Health Insurance Specialist
Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

jessica.loehr@cms.hhs.gov
(p) 410.786.4138

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled & Elderly Health Programs Group

December 5, 2017

Mr. Cory Gustafson
Commissioner
State of Vermont, Department of Vermont Health Access
280 State Drive
Waterbury, Vermont 05671-1010

Dear Mr. Gustafson:

This letter is to inform you that CMS is granting Vermont **initial approval** of its Statewide Transition Plan (STP) to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2). Approval is granted because the state has completed its systemic assessment; included the outcomes of this assessment in the STP; clearly outlined remediation strategies to rectify issues that the systemic assessment uncovered, such as legislative/regulatory changes and changes to vendor agreements and provider applications; and is actively working on those remediation strategies. Additionally, the state submitted the March 2017 draft of the STP for a 30-day public comment period, made sure information regarding the public comment period was widely disseminated, and responded to and summarized the comments in the STP submitted to CMS on July 31, 2017.

After reviewing the March 2017 draft submitted by the state on July 31, 2017, CMS provided additional feedback on October 5, 2017 requesting that the state make several technical corrections in order to receive initial approval. These changes did not necessitate another public comment period. The state subsequently addressed all issues in an updated version on November 17, 2017. These changes are summarized in Attachment I of this letter. The state's responsiveness in addressing CMS' remaining concerns related to the state's systemic assessment and remediation expedited the initial approval of its STP.

In order to receive final approval of Vermont's STP, the state will need to complete the following remaining steps and submit an updated STP with this information included:

- Complete comprehensive site-specific assessments of all home and community-based settings, implement necessary strategies for validating the assessment results, and include the outcomes of these activities within the STP;
- Draft remediation strategies and a corresponding timeline that will resolve issues that the site-specific settings assessment process and subsequent validation strategies identified

by the end of the home and community-based settings rule transition period (March 17, 2022);

- Outline a detailed plan for identifying settings that are presumed to have institutional characteristics as well as the proposed process for evaluating these settings and preparing for submission to CMS for review under heightened scrutiny;
- Develop a process for communicating with beneficiaries who are currently receiving services in settings that the state has determined cannot or will not come into compliance with the home and community-based settings rule by March 17, 2022; and
- Establish ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

While the state of Vermont has made much progress toward completing each of these remaining components, there are several technical issues that must be resolved before the state can receive final approval of its STP. CMS will be providing detailed feedback about these remaining issues shortly. Additionally, prior to resubmitting an updated version of the STP for consideration of final approval, the state will need to issue the updated STP out for a minimum 30-day public comment period.

Upon review of this detailed feedback, CMS requests that the state please contact Michele MacKenzie (410-786-5929 or Michele.MacKenzie@cms.hhs.gov) or Jessica Loehr (410-786-4138 or Jessica.Loehr@cms.hhs.gov) at your earliest convenience to confirm the date that Vermont plans to resubmit an updated STP for CMS review and consideration of final approval.

It is important to note that CMS' initial approval of an STP solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

I want to personally thank the state for its efforts thus far on the HCBS Statewide Transition Plan. CMS appreciates the state's completion of the systemic review and corresponding remediation plan with fidelity, and looks forward to the next iteration of the STP that addresses the remaining technical feedback that is forthcoming.

Sincerely,

Ralph F. Lollar, Director
Division of Long Term Services and Supports

ATTACHMENT I.

SUMMARY OF TECHNICAL CHANGES MADE BY STATE OF VERMONT TO ITS SYSTEMIC ASSESSMENT & REMEDIATION STRATEGY AT REQUEST OF CMS IN UPDATED HCBS STATEWIDE TRANSITION PLANS DATED 11/17/17

- **Public Notice:** CMS asked the state to submit its responses to public comments from the most recent public comment period in the updated STP.

  State's Response: The state submitted the detailed public comment review in its latest submission, dated November 17, 2017.

- **Waivers Included in the STP:** CMS asked the state to verify that the Palliative Care Program is included in one of these crosswalks or to explain why it is not included.

  State's Response: The state added language to the STP indicating that the Palliative Care Program is only eligible to children living in their own homes and indicating that VT presumes they meet the criteria of the HCBS settings rule.

- **Systemic Assessment and Remediation:**
  - CMS asked the state to make sure all links for reviewed state policies are active and accurate so that the documents can be located.

    State's Response: The state updated the STP to ensure that all links are active and accurate so that the documents can be located.

  - CMS asked the state to specify timeframes for respite and to note the process for authorizing respite if allowed for more than 30 days.

    State's Response: Vermont edited the CQS/STP to specify timeframes for respite for each program. Where applicable, processes for authorizing respite for more than 30 days are included (Medicaid Comprehensive Quality Strategy, p.7).

  - For the Traumatic Brain Injury (TBI) Waiver, CMS asked for clarification that the state's remediation will bring the program into compliance with the final rule by including the settings criteria.

    State's Response: Vermont edited the TBI work plan to clarify that its remediation will bring the program into compliance with the final rule by including the settings criteria.

- CMS asked the state to clarify how they will ensure that any use of restrictive interventions within its TBI waiver will be handled and documented via the person-centered planning process.

  State's Response: The state responded that they plan to use their existing TBI quality review process to make certain that any use of restrictive interventions will be handled and documented via the person-centered planning process, following the criteria in 42 CFR 441.301(c)(viii)(A) through (H). Vermont updated the TBI Work Plan to note that the provider manuals will include language for modification to the HCBS settings criteria.

Kennedy, Alice

From: Hutt, Monica
Sent: Thursday, January 04, 2018 5:47 PM
To: Tierney-Ward, Megan; Hill, Bard; George, Camille; McFadden, Clare; Courcelle, Andre
Subject: RE: Rep letter to CMS re HCBS rules

Wow- that is a shift.....

From: Tierney-Ward, Megan
Sent: Thursday, January 04, 2018 8:40 AM
To: Hill, Bard ; Hutt, Monica ; George, Camille ; McFadden, Clare ; Courcelle, Andre
Subject: Re: Rep letter to CMS re HCBS rules

Interesting. "We are encouraged to hear that CMS is currently in the process of revising this guidance...."

From: Hill, Bard
Sent: Wednesday, January 3, 2018 4:03:33 PM
To: Hutt, Monica; George, Camille; Tierney-Ward, Megan; McFadden, Clare
Subject: Rep letter to CMS re HCBS rules

..."We write today both to express our desire to see this guidance document changed, and to share our views on the value
and importance of disability-specific congregate, farmstead, and lifesharing communities in the Medicaid program. As written,
the guidance discriminates against these communities, as well as against other rural-based settings which.offer individuals with
disabilities an important choice as they consider the setting that best meets their individualized needs."
...
By painting all congregate and farmstead communities with a broad brush, CMS threatens to remove a critical choice from individuals
looking for a setting that provides individuals with a community that supports inclusion, not seclusion. We applaud CMS' intent in
the 2014 final rule to protect patient choice and dignity, but urge CMS to revise its subsequent guidance to clarify that congregate
and farmstead communities based on the lifesharing model are not subject to the heightened scrutiny standard. We understand that
these communities would welcome third party certification (such as through the Center for Quality and Leadership) as an alternative
to the current broad-brush policy."

It is change, continuing change, inevitable change, that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be.
Isaac Asimov

Bard Hill
bard.hill@vermont.gov
landline 802.241.0376
mobile 802.760.0852

Kennedy, Alice

From: Hutt, Monica
Sent: Friday, January 06, 2017 9:35 AM
To: Schurr, Stuart
Subject: Fwd: input from hearings?
Attachments: Response to Public Comment all comments 1.3.17.docx; ATT00001.htm

[redacted]

Monica Caserta Hutt
Commissioner
Department of Disabilities, Aging and Independent Living

Sent from my iPad

Begin forwarded message:

From: "George, Camille" <Camille.George@vermont.gov>
Date: January 5, 2017 at 4:28:42 PM EST
To: "Gerstenberger, Roy" <Roy.Gerstenberger@vermont.gov>, "McFadden, Clare" <Clare.McFadden@vermont.gov>, "Hutt, Monica" <Monica.Hutt@vermont.gov>
Subject: FW: input from hearings?

This is great, Clare, thanks. I'm also sharing with Monica. I'm interested to see what the input was. Do you have a process ironed out for finalizing?

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/
The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

From: McFadden, Clare
Sent: Thursday, January 05, 2017 4:24 PM
To: George, Camille <Camille.George@vermont.gov>; Gerstenberger, Roy <Roy.Gerstenberger@vermont.gov>
Subject: RE: input from hearings?
Hi Camille- I have created a document in which I have compiled all the comments, both from the hearings and those submitted in writing. I am working on creating a summary of the comments and will be meeting next Tuesday with our DS workgroup who have been involved in the regs and legal to review

what our responses will be. We will definitely be making changes, but not sure yet the extent. Attached is the document with all the comments. Do you want to be kept in the loop or weigh in on anything?

From: George, Camille
Sent: Thursday, January 05, 2017 2:41 PM
To: Gerstenberger, Roy <Roy.Gerstenberger@vermont.gov>; McFadden, Clare <Clare.McFadden@vermont.gov>; Parro, Lisa <Lisa.Parro@vermont.gov>
Subject: input from hearings?

Hi – You may not have put this together yet, but I'm wondering what the input has been around the DS regs? Do you have any notes from the hearings or other info you can share? Am interested to know if you anticipate any significant changes from what is proposed. Thanks.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

General Comments	
Public Comment Received	**Department Response**
A parent indicated that more support is needed for families who have their children living at home with them. No support was provided when her child lived at home and then the care that her adult son received in a series of 5 shared living providers was not of the best quality. People are isolated in stranger's homes. SLP sees son as money and not valued as a person The recommendation was to allow parents to be paid to provide care. Unable to keep working when having son live at home.	
parent – lives in Residential facility in NH. Concerned as him mom – aging up and the process of him getting what he needs – quite a few difficulties due to SOC to move these folks along. SOCP does not address seamless or responsive services. Has autism. Needed to wait for bed in emergency room – then to Brattleboro – then titrated meds then – system not set up to respond immediately. Concerned how changes will affect him going forward. Considering his medical condition – needs a RN attention due to heart issues. Can still use VNA perhaps? (depends). Other families having difficulties – didn't have the right supports at discharge and back at institution. Didn't have a needs assessment at home where they don't have the same level of support.	
I am a family member of a 8yr who gets developmental services. I family manage son's services and use an independent service coordinator. I have just heard about these proposed regulations and there's no way I can come in by your deadline you need to get information out to families before you move ahead on this because it affects our lives.	
Proposed rules should be presented in a way that is accessible and understandable for consumers and families. HCBS emphasizes providing accessible materials.	
You want comments submitted to you by Dec 30,2016. Seems to me there should have been more of a notice! 77 pages and it is Dec 27,2016. Not everyone has a group of people to read and figure out exactly	

what you are saying! Not that I planned on it but I was curious. Why not make things in plain english instead of this refers to that or from one point to number whatever. I honestly thing when you write laws etc you want to make things as confusing as possible so the ordinary tax payer cant follow what you are saying. Is it really necessary to write so many pages. Make things simple . Just commenting on what was in paper.	
We have also read Vermont Legal Aid's responses to many of the changes and agree with them that they are at a minimum detrimental, with most extremely harmful to the health and well-being of our state's disabled population. We also find the changes to be near-sighted cost savings that in the long run will cost Vermont exponentially more in hospitalization, criminal justice and employment for these individuals. But even more egregious is the irreparable harm they will do to their personal and social lives. We learned about the proposed regulations through a friend just the other day, and many families are unaware of them. Also, the timing for comments in extremely upsetting, since this is the holiday season and families are already overwhelmed with personal demands this month. We ask that you delay the time for comments until individuals and families are notified about these changes that will affect their lives and are given time to comment. We also ask that you review the proposed regulations and make the changes needed to ensure that the rights for disabled people under federal statute are affirmed. I find it difficult to believe that any significant changes to determination or implementation of services would be made when the very agencies and consumers you serve have not been notified of such changes, thus have NO significant time to review or comment on such changes. I ask for an immediate delay in this process, and appropriate action taken by the Department of Developmental Services to	

insure every community member, their guardians and families, whom may be effected by these changes, have time to review and comment on same.

I know that it has taken a lot of work and effort to get to this step. At the same time it is important to get it right by ensuring the regulations cover the key categories in Act 140, are consistent with the new federal Home & Community-Based Settings requirements, and are based on input from the individuals and families whose lives are affected by the regulations every day.

Based on those principles I strongly urge you to postpone filing the proposed rules until the proposed regulations are revised so that they address the federal HCBS Rule and the categories required by Act 140, and there can be a full and complete public input process. I know that I did not have the information and tools necessary to adequately review the proposed regulations in the time period before the deadline. At this point I would like to point out the reasons why the comment period needs to be extended and the proposed regulations revised:

1. The public input process is defective because stakeholders were not notified; full and complete materials were not posted online; and the comment period over the Christmas holiday gave virtually no opportunity to either get word out to people or for people to respond.
To underscore the problems I heard about the proposed regulations inadvertently from a DAIL employee a day before the first hearing in a phone call about another matter. I don't know any other parent who got direct notification from the State or an agency. I was able to attend the hearing a day later in Waterbury so received a paper copy of the DAIL Summary of Changes. The document was not posted online so was not available to those who could not attend the hearing, and the Summary does not explain the actual impact of the changes on people and their services. The timing makes it look like the Department did not want public knowledge or comments, with the release just before Christmas and comments due back December 30 in the middle of the Christmas season for most families. This is the period when the key family organizations – Vermont Family Network and Vermont Federation of Families for Children's Mental Health – are essentially closed for the holidays until after New Year's Day..

Federal Home and Community-Based Rule. This regulatory process is the ideal vehicle for Vermont to demonstrate its commitment to the requirements of the

recently implemented federal Rule. Yet it is a missed opportunity because the proposed regulations do not address key elements of the Rule. Testimony by Green Mountain Self-Advocates on December 15 emphasized that the regulations are not written in a way that is understandable to people as required by the Rule. The Rule also stressed that people need to have information and support to direct their own services and make choices among service options. In sum, the proposed regulations need major revisions in order to meet the requirements of the federal Home and Community-Based Rule and Act 140. They need to lay out viable options for people to have self-direction and choices about services and supports. The regulations also need to provide viable alternatives to agency-run services, rather than increased agency involvement in self and family management options. Once the regulations are revised notice needs to be sent to all individuals and families served by the system, in ways that will reach them, with plain English explanations. That could include a mailing through ARIS with their bi-weekly reports, and through agencies. And there needs to be sufficient timeline so that people can respond.	
Any proposed changes that are contradictory to Federal Laws and Regulations should also not be considered. I appreciate and support VT Legal Aids Comments regarding some of the proposed changes which are contradictory to Federal Law.	
Global issue – helpful to understand if SSCP is going away – just be regs? 3 yr reg change? Need to understand how it will look in future as to public input	
Spirit of HCBS rules – not seeing them in regulations. New regs say that person needs to lead their ISA process (Plan) or how we are going to teach people to do this or how to ensure it will happen. More rigor that people have choice, presented with different options, presented with choice and that choices are honored (follow-up)	
Overall comment – have key issues address in regs instead of SSCP – seems it was referred to instead of info being in regs	

Are there enough protections – need to consider the next few years	
Need to get more input from families on regs	
The proposed rules identify significant portions of the State System of Care Plan. As a result, we are concerned about small details necessitating rule changes in the future. For example, increasing the amount that will be paid for dental from $1,000 to $1,050 per year.	
Additionally, despite inclusion of such details, the rules continue to reference a System of Care Plan; however, the proposed rules leave significant questions about the content and purpose of future State System of Care Plans. Designated agencies (DAs) have been required to provide input into the State System of Care Plan in the form of a Local System of Care Plan. Yet the Local System of Care Plan that is required of them no longer seems relevant as priorities for services are already incorporated into the proposed rules such that DA input seems to have no place to be utilized once received. In light of the proposed rule changes impact on the content and purpose of the State System of Care Plan, we are unable to provide feedback where there is reference to the System of Care Plan in the proposed rules. My first concern is there is serious inconsistency in portions of what is proposed and what are our 10 Core Principals we stand by as the Department of Aging and Independent Living. Any proposed changes that limit or impede on our 10 Core Principals should not be recommended.	
Another document referenced multiple places in the proposed rules is the *Medicaid Manual*. The current manual is dated July 1, 1995 with some information updated in January 1999. This manual is out of date and our understanding is that DAIL is working on updating it. We have not yet been provided a draft for review and feedback; and therefore, for clarity we recommend that all references to the Medicaid Manual state: *Division of Mental Retardation Medicaid Manual July 1, 1995 and Division of Developmental Services Medicaid Manual Updated Information –January 1999.* We	

recognize that may necessitate updating these regulations again soon, but our feedback cannot be viewed as complete and accurate without knowledge of what requirements may be included in a *Medicaid Manual* update. Parent finds that several of the proposals are in direct conflict with federal home and community-based services rules that say we should have options to choose from, and conflict-free case management.	
DAIL has included changes in the proposed regulations that we welcome philosophically. DAIL has also acknowledged the underfunding agencies are experiencing trying to meet current expectations. Therefore, we are anxious to learn the amount of new funding that has been requested to fund the expansion of services and cover new administrative requirements such as enhanced training.	
Act 140 required four specific categories to be addressed in regulations, (1) priorities for continuation of existing programs;(2) criteria for receiving services or funding;(3) type of services provided; and (4) a process for evaluating and assessing the success of programs. The proposed regulations appear to add to the existing regulations without the necessary in-depth examination of what needed to be shifted from the System of Care Plan and policies to the regulatory scheme. Examples of items left out are the equity committee structure that impacts access to services and funding. The most conspicuous missing service is shared living, even though it receives the greatest amount of funding. There is virtually no mention of this home support option, and no regulation of home providers. Agencies are not even required to include these subcontractors in their training (Part 9). And there is no definition of "wrap services, an option that allows shared home providers to manage virtually all of a person' services. Contrast this lack of regulation – and State oversight -- with the rigorous scheme imposed when people self or family manage.	
make strong recommendation that we seek to provide Home Providers a raise as they have not had a raise in some 15 years or so. Home Providers need to be a part of the Team of agencies and as such need to be paid on par with other agency staff. I assert that Home Providers need to be involved in Plan development with	

client/consumers as they are often very informative of client interest and abilities that otherwise would go unnoticed.	
Additionally, the whole crisis situation with our son in the ED, his stay in Wardsboro and at the Brattleboro Retreat was challenging, traumatizing and frightening. What could we have done differently? Are these issues being addressed in the legal narrative to protect people like Jacob and other families from going through similar circumstances? During this process we tried our best to look for Medicaid providers willing to support Jacob and his med cleanout, but the process was so slow and the circle of crisis continued to spin. I believe we may put the individuals we serve at risk for our process is **slow**. Can we put something in the language that would avoid all this in order to get families access to treatment faster? Also, is there a way to have a crisis bed for people with disabilities in every county? Additionally, there were times in this process where quite possibly an administrator may have been making a decision that truly was beyond her scope. Remember that Jacob has complex medical needs. Instead of just allowing the medical provider in Brattleboro to drive the bus in terms of when discharge should happen for our son, in my opinion this admistrator continued to push and push. (Jacob had a grand mal seizure as a result of the quick take down of his medication). Is there a way to protect people like Jacob with further language that supports this from happening to other families? Was there an alternative to Brattleboro that perhaps we should of considered that was not part of our due dilligence? Additionally at discharge and beyond, is there a way to incorporate language to have more qualified people on the ground? Shouldn't our mental health system build more on the ground alliances with community members, police, medical staff, each other? Shouldn't these folks be well trained, supported and given a liveable pay rate? What can we build into the narrative to	

protect people like our son in similar situations and make DA's accountable?	
1. They were hard to understand. Once they are final we would like to work with you to make them easier to read. The chart was helpful but the words are hard to read. When we do work with the Health Department we have been trying to write information on a 6th grade level. That is what the CDC recommends. 2. We support the comments sent in by the Disability Law Project and the DD Council. Please send us your answers to all the comments - Thanks. 3. We thought we heard you say these regulations will be VT's Transition Plan. We think the Transition Plan for the HCBS rules should be separate. We feel that the regulations do not talk about all the HCBS rules. For example, they do not explain how Vermont will do conflict-free casemanagement. The regulations do not address the segregated day programs at some of the agencies. Vermont must keep its commitment to individualized services.	3.(from Roy) These rules are not the Transition Plan for Vermont. Some wording has been changes to support the new HCBS rules but they are not meant to be a plan. I also want to share that our state is going to use the document called the Comprehensive Quality Strategy – or CQS – to describe how our system will meet the HCBS rules. So, when we talk about our transition plan for Vermont you will sometimes see or hear the term CQS or Comprehensive Quality Strategy. At this point there is only a plan for elder services to meet the HCBS rules. When we work on a plan for developmental services I expect to have an open and public process. You can find the CQS at the following web address. If you look on page 8 in the introduction and also on page 5 in the section "Assessment of HCBS Setting Requirement for Other GC Programs" you will find descriptions of what I have tried to explain: http://dvha.vermont.gov/global-commitment-to-health/1vt-gc-cqs-september-15-2015-cms-submission.pdf
Part 1. Definitions	
The proposed regulations also do not define specialized services. The only mention of "nonpayroll services and supports" appears to be at Part 5, and the proposed regulations appear to limit choices rather than expand options for innovative non-payroll services and supports like Safety Connections.	
1.1 Adult. People age 18 who attend school are a subcategory of "adult" whose services are provided in conjunction with VT IDEA	

Rules	
Section 1.1 The definition of **Crisis Services** should be amended to include supports needed for individuals experiencing ***unexpected loss of housing.***	Crisis Services are specifically for when a person is experiencing an emotional or behavioral crisis. An unexpected loss of housing does not always result in crisis as alternative housing can be arranged.
1.2 The definition of *Agency* has been changed to read the DA and the SSA. We recommend the language be changed back to say the DA *or* SSA. As *agency* is used in the regulations, the tying of DA and SSA makes more than one agency responsible. This will create confusion and likely some management issues.	Do a word search to see if meaning is correct in all circumstances.
1.3 QDDP. Should this section be included or is the QDDP independent of the Department?	spsc
1.5 The definition of *Authorized Funding Limit* includes a list of funding. We recommend this definition be simplified to state that it: *means all funding related to an individual's HCBS budget that the person takes with them if they transfer to another agency.*	The suggested change does not provide enough clarity regarding what funds would be available to transfer to another agency. The intent of having an AFL is so that consumers are aware of what funding is available to them to purchase services.
1.8 The *Clinical Services* definition includes in the last sentence "that cannot be accessed through the Medicaid State Plan." We recommend this be changed to read *that is not available* through the Medicaid State Plan. Services must be available for people with I/DD from providers with the training and expertise to meet the person's needs, which is not always possible to obtain through the Medicaid State Plan providers. 1.8 Clinical Services" definition must include services "that cannot be accessed through the Medicaid State Plan ***including services not available due to coverage limitations or because they are not available at the Medicaid rate*** " In our experience, some individuals are accessing clinical services through developmental services because they require services beyond coverage limitations in the Medicaid plan, because the qualified providers bill beyond the Medicaid rate, or because in that geographic region there are no qualified providers billing at the Medicaid rate.	Need to think about this. Barb has some additional language suggestion as well. Not sure "is not available" is better.

1.8 "Clinical Services" definition must include services "that cannot be accessed through the Medicaid State Plan *including services not available due to coverage limitations or because they are not available at the Medicaid rate."* In our experience, some individuals are accessing clinical services through developmental services because they require services beyond coverage limitations in the Medicaid plan, because the qualified providers bill beyond the Medicaid rate, or because in that geographic region there are no qualified providers billing at the Medicaid rate. 1.8 "that cannot be accessed through, or are available through, the Medicaid State Plan.	
1.11 We recommend that *or a significant event* be added at the end of the first sentence of the definition of *Crisis Services.* 1.11 "Crisis Services" definition needs to include supports for individuals experiencing ***unexpected loss of housing.*** ***1.11*** "Crisis Services" definition must include supports needed for individuals experiencing *unexpected loss of housing or a significant event.* Some of our clients have needed crisis services because of the unexpected loss of housing, through death of a family member or unexpected termination or resignation of a home provider.	This came from VCP- need to ask for clarification. That's a broad and vague term.
1.14, 1.40, 1.42 Role, responsibilities, reporting, training, confidentiality, relationships with the Division, need to be clarified and elaborated. This is also a need throughout Part 5, Self/Family-Managed Services.	spsc
1.18 We recommend that *and for maintaining employment* be added at the end of the first sentence of the definition of *Employment Supports.*	Second sentence includes support to maintain a job, so not sure it's necessary to repeat.

1.21 In the definition of *Home and Community-Based Services* we recommend the addition of congregate so the definition reads: an institutional *or congregate* setting...	This would require a definition of "congregate". This could limit some current options such as day programs, Heartbeet, Global Campus?
1.21 In the definition of *Home and Community-Based Services* we recommend the addition of congregate so the definition reads: an institutional *or congregate* setting...	go back to VCP as this is a repeat, did I miss one.
1.26 In the definition of *Network* please add *or arrange* between to provide and developmental disabilities services to be consistent with State Statutes.	Yes. We will make this change.
1.31 We ask that DAIL inform DAs of the purpose of the System of Care Plan they are being asked to develop and submit to DAIL incorporating needs in their community since the State System of Care Plan will no longer address how resources are utilized.	ok
Section 1.33 The definition of **Respite Supports** should be amended to eliminate the provision limiting Respite Supports to individuals who "cannot be left unsupervised." This requirement unreasonably limits the availability of Respite Supports and fails to capture the legitimate need that family caregivers may have for respite regardless of the ability of the family member with a disability to manage their needs independently for limited periods of time. 1.33 The last clause of the "Respite" definition should be eliminated. The requirement that respite is only for people who "cannot be left unsupervised" unreasonably limits who can receive respite services. Many recipients who receive respite can be "unsupervised" and still need respite supports. Respite is often essential for family caregivers and stability of care, even when individuals with disabilities are able to care for themselves for limited periods of time. 1.33	Definition will be modified to substitute "cannot be left unsupervised" to "needs the support of another caregiver".

The last clause of the "Respite" definition should be eliminated. The requirement that respite is only for people who "cannot be left unsupervised" unreasonably limits who can receive respite services. Many recipients who receive respite supports can be "unsupervised" and still need respite supports.	
1.36 How do the services defined in Part 1 correlate with the service definitions in the Global Commitment waiver and are there implications associated with differences?	Good question. As defined here, it means all Medicaid services. As that what we mean when the term is used in the regs?
Section 1.42 The definition of **Supportive Services** should include ***therapeutically appropriate*** services in addition to medically appropriate service. pg 9 description of supportive services – only those that are medically appropriate but not all are medical – some are therapeutic – such as sexuality and sex offender treatment. 1.42 DAIL defines a new service category of *Supportive Services*. We recommend the last sentence be revised after the semicolon to read *and other services provided by individuals qualified by training and expertise.* 1.42 The "Supportive services" definition is too narrow. "Therapeutic" should be added, so that the second sentence reads "*therapeutically* or medically appropriate services." 1.42 The "Supportive services" definition should not be limited only to "medically appropriate" therapeutic services. "Therapeutic" should be added, so that the second sentence reads "*therapeutically* or medically appropriate services" Services like sexuality training for abuse victims or sex offender training are not necessary "medical" services but are therapeutically necessary and important.	Consider this term. Google it in health ins to see if has a meaning. This language opens the option to widely. Who determines who is qualified? E.g. some one could say that manicures are therapeutic.

1.42 "These are ~~medically~~ appropriate services that include..."	
Section 1.44 The definition of **Transportation Services** should include coverage for ***transportation to access medical appointments, crisis services, clinical services and respite supports.***	A line item for transportation in a HCBS budget is only available for accessible transportation and mileage for community supports. Reimbursement for transportation to medical appointments, including clinical services, is available through the Medicaid State Plan. Transportation for crisis services is included in the cost of that service. The intent of respite is to provide a break for the primary caregiver and although it may be provided in the community, the primary purpose is not for involvement or participation in the community. Therefore, mileage reimbursement is not offered for this service. There are not sufficient resources to expand access additional funding.
1.44 Transportation services" needs to include coverage for transportation to access *medical appointments, crisis services, clinical services, and respite supports.*	
1.44 We recommend that the definition of *Transportation Services* be changed to read: *means acquisition and maintenance of accessible transportation for an individual or reimbursement for mileage for community supports.*	The definition will be modified to include this suggestion as follows: "Transportation Services" means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member or reimbursement for mileage for transportation to access Community Supports.
As outlined by Vermont Legal Aid in its detailed list the proposed regulations also limit choices and options in numerous ways by arbitrarily capping and limiting services and supports. An example is transportation services, which would be provided only for work or community supports. That arbitrarily limits how people can access a range of other services including respite. 1.44 "Transportation services" needs to include coverage for transportation to access *medical appointments, crisis services, clinical services, and respite supports.* Otherwise, transportation costs would only be available for community supports or work supports. This is inadequate.	

1.44 Only for transportation services that are not family provided. Barb Prine was working on wording.spsc	
1.46 Why do the definitions include a definition of a *young child* and an *adult* but not a definition of a child? There is a need to clarify the difference between a young child and a child.	The definition of a school aged child is in 2.3 (a). We could add that back into definition section.
Pg 4 sec 1.8 Clinical svs – include svs that are not available through Medicaid State Plan should be clearly explicitly stated – like when not enough $	Wait for BP input
Part 2. Criteria for Determining Developmental Disability	
VT using test scores to determine eligibility vs using DSM adaptive functioning test.	
autism – require a clinician comment as to why now if dx later in life – awkward to have clinical comment on fellow clinician's previous work – is there another way to do this	
Different eligibility criteria for different people – unfair – focus on person's functioning as with DSM – sometime IQ is top of the list, other times not look at IQ at all – need one standard. Know it's in DD Act. Doesn't make sense – question whether office of civil rights fair to have two standards	
Does the change in definition from Pervasive Developmental Disorder to Autism Spectrum Disorder change who is eligible for services?	The definition of ASD is slightly narrower than PDD. The DSM-5 includes criteria that allows for the diagnosis of ASD for those who previously had well established PDD diagnoses. Also, the proposed regulation will only apply to people newly applying for services. Current recipients previously found eligible under PDD will continue to maintain their eligibility for services if they continue to display the same symptoms that led to their diagnosis.
Section 2.6 (h) This is a new Section and it has the potential to make Vermont's criteria for determining whether an	This section was added to provide clarity that the criteria for eligibility is as stated in these regulations and not the criteria in the DSM.

individual has an intellectual disability more restrictive than the criteria set out in the Diagnostic Services Manual (DSM). The DSM correctly relies more on adaptive functioning than test scores when determining the level of services needed. 2.6(h) The Intellectual disability criteria should be consistent with DSM-V criteria to ensure appropriate access to services. The DSM-V correctly relies more on adaptive functioning as the basis for the level of services needed. The proposed language is unnecessarily restrictive. 2.6 (h) The Intellectual disability criteria is more restrictive than the criteria in the DSM-V. This is problematic as it continues to restrict services to individuals. The DSM correctly relies more on adaptive functioning rather than test scores as the basis for the level of services needed.	There was no actual change from the previous version of the regulations. The criteria in the current DSM is broader than the criteria in these regulations. Using the DSM criteria would significantly increase those who could be found eligible for DD services. Check definition in DD Act. The Department feels that the current definition is consistent with the intent of the Act and targets services to those most in need.
Section 2.10(g) The last sentence of this Section adds an unreasonable, impracticable, and possibly unethical requirement for clinicians who diagnose an adult or child in their late teens with an Autism Spectrum Disorder and should be struck. For such individuals, **the clinician must clearly articulate a rationale for the diagnosis, particularly when other previous diagnoses had been rendered to explain symptoms.** This new requirement is unduly burdensome as it requires clinicians to disparage or second guess their colleagues and/or their own prior diagnosis. 2.10(g) The last sentence of this section is not in alignment with Vermont values and ethical practices and should be struck. Requiring	Maybe think of a better way of emphasizing differential diagnosis or older children and adults.

clinicians to articulate reasons why an autism diagnosis was not made earlier is unfair and unnecessarily limiting of services to people with ASD who are diagnosed later in childhood. 2.10 (g) The last sentence of this section should be struck, requiring clinicians to articulate reasons why the diagnosis was not made before. This is new prescriptive language, and seeks to restrict access to those diagnosed later in childhood.	
Another comment I have is in reference to the diagnostic criteria for older adolescents and individuals as opposed to being diagnosed in early childhood. Will the terminology used in the proposed changes narrow the window for people accessing treatment and services? There may have been some real reluctancy on the part of the parent or guardian for the stigma of having a "label" may pose as a real issue to some. We would not want to impede this process by putting up more road blocks for people needing help. It's a stigma for parents or people to get that diagnosis, but then there is a realization that a diagnosis is needed to get supports.	
Part 3. Recipient Criteria	
3.1 (a) The phrase that individuals must "meet the criteria for financial eligibility" to be a recipient should be struck. Some recipients private pay for services, and those that do have many of the rights of recipients under the DD Act and these regulations. 3.1 (a) The phrase that individuals must "meet the criteria for financial eligibility" to be a recipient should be struck. Some recipients private pay for services, and those that do have many of the rights of recipients under the DD Act and these regulations.	

3.1 (a) Does a recipient include/protect individuals who are paying privately for specific services?	
Part 4. Application, Assessment, Funding Authorization, Programs and Funding sources, Notification, Support Planning and Periodic Review	
some see more appropriate for SSCP – more programs than services	
-New limits/numbers – like 19 to 18 – others seem aubitray (age 22 to 21, number of hours for CS/WS -likes moving CS/WS from 19-18	The limit of 25 hours a week for work supports and community supports was established in previous SOCPs as a method of managing limited resources. The Department cannot increase this limit without a significant increase in resources. 25 hours a week provides a fair amount of time for support to participate in the community. With regards to employment support, there is an expectation that a person expand their ability to work more independently rather than expand the hours they receive support to work.
FMR – not change from 22 to 21 – impact on special ed svs	
4.3(b) We recommend the language be changed to read: *An application for a person who has never received services and...*	
4.3(c) We think that "DA" was mistakenly left in the first line such that the sentence does not read correctly and should be removed.	
4.4(a) There are extenuating circumstances that can impact the DA meeting this 5 day requirement. For example, a family applies and then goes on a vacation. We believe the language should be changed to read: Within five...the DA shall *make a good faith effort to* complete...	
4.4(a) (4) We recommend this be changed to read: *Determining whether the person with a developmental disability or the person's family is in need of immediate implementation of one or more services within 60 days. If the DA determines that the person or family mandates service implementation, the DA has the option of making a temporary decision on the application.*	

4.4(b) (1) We recommend removing the last clause that starts with including. It is redundant since the regulations define DAs and SSAs as the only certified providers.	
4.4(c) We recommend that the subjective descriptor "fully" be removed from the newly added last sentence of the clause. 4.4(c)/ 4.11 The language her and elsewhere in the regulations that designated agencies must document that they provided recipients with their options is a positive strengthening of the choice of provider rules. 4.4 (c) Omit "fully" in 2nd and 4th sentence. Too broad. Families should get documentation from DAs so it is clear what has been discussed.	
This question is answered through a uniform needs assessment and process approved by the Department,...spsc	
4.5(c) (3) This clause eliminates the System of Care Plan in favor of these regulations so again raises questions about the role of any System of Care Plan.	
Section 4.6 This Section strikes the requirement that the funding amount authorized shall be equal to the amount needed to pay for the supports requested by the applicant or family that fit within the System of Care Plan funding priorities. This requirement is essential to ensure that there are sufficient funds to provide the services determined to be services provided under the DD Act. Without this sentence, funds could be cut, but the expectation that services continue will remain. 4.6 As previously stated, we are unclear of the purpose and content of the System of Care Plan. This clause reflects that it holds the "procedures for authorizing funding or services."	

However, since services and priorities are included in these rules, we are not clear what that statement means. The clause reflects that the amount of services funded will no longer be tied to what is needed to fund supports the person requires and that fit within the System of Care plan funding priorities, but rather will be based on "the most cost effective method of meeting an individual's assessed needs." We agree that we need to continue to be a cost effective system; however, we recommend that language be changed to read: *Services authorized shall be based upon a cost-effective method of meeting..."* The clause then references that such authorizations will be guided by the System of Care Plan and the Medicaid Manual for Developmental Disabilities Services Division. As previously stated, the role of this plan is very unclear in the context of the proposed rules and the current Medicaid Manual should be reference since it is the only currently available manual. 4.6 This sentence must not be deleted: "*The funding amount authorized shall be equal to the amount needed to pay for any support needs requested by the applicant or family that fit within the System of Care Plan funding priorities.*" This sentence is essential to ensure that there are sufficient funds to actually provide the services determined to be services provided under the DD Act. Without this sentence, funds could be cut and the expectation that services would continue to be delivered would remain. 4.6 It is imperative that this sentence not be deleted. "*The funding amount authorized shall be equal to the amount needed to pay for any support needs requested by the applicant or family that fit within the System of Care Plan funding priorities.*" This sentence is essential to ensure that funds are sufficient to meet the needs of what the state and regulations have determined to be services provided un the DD Act. Without it funds could be cut,	

bust an expectation continue that services will be delivered. 4.6 The funding amount authorized shall fit within, be equal to the amount needed to pay for support needs requested, be approved within the System of Care Plan Funding Priority, and consistent with DDSD guidelines and criteria for the evaluation. spsc	
4.7 The opening paragraph states that additional details and requirements are specified in the *Medicaid Manual*. Again we recommend the rules reference the manual currently in effect. The section includes some Medicaid State Plan coverages but not all that are currently in the Medicaid State Plan for Developmental Services. Therefore, it is unclear what Medicaid State Plan Services will continue to be available. This section identifies a list of services the Developmental Services Division will fund, criteria to access them and limitations of the services, including funding caps. We believe this entails much more detail than is necessary and may eliminate flexibility to meet individual's needs. Such details would render funding appropriation changes undeliverable until such time as regulations were changed. In addition, the section repeats things that are specified in DAIL Guidelines. As such we think, the list of services should be eliminated. We also think funding limitations should be eliminated and question whether the use of such limitations is consistent with mental health parity laws. However, in the event that the list is retained we have the following questions and recommendations for modification.	
4.7 Vermont needs to do a more in-depth look at innovative services and options being used nationally and provide room within the regulatory structure for them. **4.7** 1. Programs listed should describe type/category of service, not specific program title, as within different DA/SSA, program titles can be different for the same service.	

2. Wherever listed, specific $ amounts shall include the wording:" for $ not below "	
4.7(a) This section references an EPSDT service – Bridge Care Coordination. How does listing one EPSDT service in these regulations impact access to other EPSDT services? 4.7(a) ~~Bridge Program; Care Coordination for Children with Developmental Disabilities~~ **spsc** **Section 4.7(a)(1)(c)** This Section limits the availability of the Bridge Program to families in areas of the State where there is not an Integrated Family Services Program. The Bridge Program is an Early Periodic Screening Diagnosis and Treatment entitlement service and must therefore be available statewide and without waitlists. 4.7(a)(1)(c) Limiting the Bridge program as "only available to families where there is not Integrated Family Services" ignores that fact that this is an entitled service under EPSDT and must be available to families statewide without waitlists. 4.7(a)(1)(c) The "Bridge program only available to families where there is not Integrated Family Services" – is a service that is an entitlement services under EPSDT and must be available statewide without waitlists.	
4.7(a)(2) Case Management services which may include Care Coordination (Bridge). Type of $ this is needs to be specified. spsc	
4.7(b) We recommend changing from This plan covers to *This plan addresses.* 4.7(b)(2) We recommend the dollar caps identified in (A) and (B) be removed. We	

recommend "covered" be removed from (E) and replaced with *otherwise reimbursed.*	
4.7(c) We recommend the cap of $5,000 be removed in (2).	
4.7(d) Definitions of Family Managed Respite, Respite Supports (1.33), and Children's Personal Care, need to be updated and included. spsc	
Section 4.7(d)(2)(D) This Section regarding Family Managed Respite raises 2 issues. First, the maximum amount of services allowed cannot be delineated in the System of Care Plan. Amounts of service should be included in the Regulations. Second, the age limit for Family Managed Respite is currently 22 years. This should remain 22 and not be reduced to age 21. 4.7(d)(2)(D) The maximum amount of Family Managed Respite cannot be in delineated in the System of Care Plan. Amount of services are part of what must be included in the regulations. 18 V.S.A. §8724(a) (2). The age limit for Family Managed Respite is currently 22 years. This should remain 22 and not be reduced to age 21. 4.7(d) (2) We recommend that the reference to a cap being identified in the System of Care Plan be removed. 4.7(d)(2)(D) Family Managed Respite – the maximum amount allowed cannot be in delineated in the System of Care Plan. Amount of services are part of what must be included in the regulations. 18 V.S.A. §8724(a)(2) . The age limit for Family Managed respite previously was age 22. This should remain up to age 22 and not be reduced to age 21.	
Section 4.7(e) This Section contains new restrictions for Flexible Family Funding that limit funding to services that	

enhance a family's ***ability to live together.*** This is a vague aspiration that should not be a requirement for funding and should be struck. 4.7e – respite to enhance family to live together – subjective 4.7(e) (2) We recommend the cap of $1,000 in (D) be removed. 4.7(e) The purpose or meaning of the new language that Flexible Family Funding is limited to services that enhance a family's "ability to live together," is unclear. This should be fully explained or removed. 4.7(e) We do not understand the purpose or meaning of the new language added that Flexible Family Funding is limited for "enhance their ability to live together". This appears to be a new limitation that should either be explained or deleted.	
4.7(f) 4.7(j0 and 4.7(l) Descriptions of Global Campus Post-Secondary Ed and Project Search programs do not belong in the regulations; the regulations are about *services*. 4.7 (f) ~~Global Campus- Life Long Learning (would include Succeed, Global Campus, etc.)spsc~~	
4.7(g) This section states that the services listed comprise <u>all</u> services that may be provided to a person and paid for in the daily rate. Does this mean that other needed services could not be provided without a rule change? It does not specify that the daily rate may include administrative costs to provide the services. In addition, all services in the specified list are not identified in the current System of Care Plan or Medicaid Manual; however, this section indicates that full definitions are included in the documents. We recommend that the first	

paragraph be re-written to read: *Developmental Disabilities HCBS are long term services and supports provided throughout the state by private, non-profit developmental disabilities services providers, or through self/family-management, to adults and children with developmental disabilities who have the most intensive needs. The budgets are based on an all-inclusive daily rate that combines all applicable services and supports provided to the individual in accordance with their needs plus associated administrative expenses. Services and supports may include service coordination, community and/or employment supports, respite, clinical and other supportive services, crisis services, home supports and transportation.*	
4.7 (g)(1) (C) In addition I would also like add, I feel the limitations on children's services over the last 10 years has also had a negative impact on Vermont Families. I see over and over again families who are burnt out, overwhelmed with their child's needs and unable to cope without the mandated EPSDT services they are entitled to. I have seen children in Residential Care and DCF custody who should not be, due to the lack of community based services by a DA. I have seen evidence over the years of the fact that unsupported (over burdened, over taxed, tired, exhausted) families do not teach new skills which produces more profoundly disabled adults unnecessarily. The schools are not meeting ALL the needs of most children, and providing the bare minimum if the parents are able or know how to advocate for them. The notion that families and schools can meet the needs of all children with developmental disabilities until the age of 22 is ridiculous and is producing more costs to meet the needs of adults for ongoing decades. Our limitations in our children's system of care is intentionally supporting and creating persons with extreme challenges and manipulative behaviors by not being given the intense early interventions by qualified individuals as children. The less we give children and families, the more profoundly disabled our community will be. This is sad and we need to bend the curve on this with	

recommendations that support our 10 Core Principals and **does not limit them**. Families need services that completely comply with our values and principals, and support a stronger and more independent population of persons with special needs.	
4.7(g)(1) In (C)(i)(1), it specifies that access to services is dependent upon the eligibility for ICF/DD level of care. Do we still need to apply this former 1915(c) criteria since the Global Commitment Waiver explicitly identifies that VT sought and received approval for "Removal of Institutional Bias" for developmental disabilities? In (C)(i)(3), it identifies that individuals must meet one of six funding priorities, which follow in (A) to (F). If these criteria are included in regulation, what would be included and the purpose of a System of Care Plan? (C)(i)(3)(A)(i) defines imminent for (A) as 45 days, and we think these criteria should be removed. In (C)(i)(3)(F), the funding level is capped, does this mean that this level cannot be increased without a change in the rules?	
4.7(g)(2) In (A) it indicates that the services must be the "most cost effective option." We too think a cost effective system should continue to be maintained, but specifying that services must be the most cost effective may lead support options provided that are not the choice that is desired or best for the individual. We recommend it be revised to say *Services and supports must be cost effective and meet the individual's...*	
4.7(g)(2) B) Specifies that all Medicaid State Plan and Medicare services must be accessed before using HCBS. We recommend it be rewritten to reflect the need for individuals to have access to qualified providers. *All services that can be funded through Medicare, Medicaid State Plan and/or private insurance must be utilized prior to using developmental disabilities funding when qualified, competent providers are available in the individual's community.*	

Section 4.7(g)(2)(D) This Section prohibits funding for services that duplicate or substitute for natural and/or unpaid support. The new federal Home and Community Based Services regulations define natural and unpaid supports as voluntary. Accordingly, this funding prohibition should be struck. See, 41 CFR 441.301(c)(2)(5). 4.7.g.2.d- address funding to pay natural and unpaid supports – referenced as voluntary – hard to implement 4.7(g)(2)(D) Funding must not duplicate or substitute for natural supports or unpaid supports – this language should be struck, as it is in conflict with the federal HCBS regulations that define natural and unpaid supports as voluntarily provided, 41 CFR 441.301(c)(2)(5) 4.7(g)(2)(D) Funding must not duplicate or substitute for natural supports or unpaid supports – this language is in conflict with the federal HCBS regulations that define natural and unpaid supports as voluntarily provided, 41 CFR 441.301(c)(2)(5)	
4.7(g)(2) (E) Specifies that funds must be utilized in accordance with the System of Care Plan and Medicaid Manual, which as previously noted is problematic. It also specifies that they must be utilized in accordance with the Federal HCBS Rules, including provision for conflict-free case-management. Vermont has yet to submit a plan to the Centers for Medicaid Services specifying how they will meet the Federal HCBS rules, including provisions related to case-management. We think this very specific statement is premature in the absence of a plan having been submitted. There should be clear requirements and meaning to a statement such as "provisions for conflict-free case-management" before it is incorporated into regulation.	

4.7(g)(2) In (F), we recommend modifying the third sentence as follows: For up to one calendar year...fund (Equity and Public Safety) *except in situations where there has been a budget reduction instituted during the year.*	
In (I), we recommend (i) be rewritten as follows: *Residential settings are defined as individual addresses owned and operated by a single person or entity, not as an intended community.* In (I) (i) and (ii), we recommend the sentence providing authority for the Division to allow exceptions to the requirements be removed.	
Section 4.7(g)(2)(J) This Section limits the amount of community or employment supports an individual can receive per week to 25 hours. In general, program parameters such as these may be more appropriately contained within the System of Care Plan and not codified in Regulations. Regardless of where it is located, the 25 hour limit should be struck as it restricts opportunities for community integration and work, two essential activities which are known to greatly enhance one's quality of life and health. Furthermore, the limit will reduce access to home providers who typically work 40 hours a week. 4.7(g)(2) (J) Includes a number of restriction on service hours that people may receive. We recommend removal of the hour limits. It is particularly problematic to restrict the number of hours someone can be employed based on their support needs. 4.7(g)(2)(J) This limit feels arbitrary and counterproductive. Recipients must be able to access more than 25 hours of community or employment supports. The proposed limitation restricts opportunities for community integration and work. Home providers	

typically work 40 hours a week, so access to home providers would be less, as well. 4.7(g)(2)(J) Recipients must be able to access more than 25 hours of community or employment supports. This limitation restricts the opportunities for community access, and the pool of home providers as home providers typically work 40hour a week jobs. This is an arbitrary limit. 4.7(g)(2)(J) Funding must not duplicate or substitute for natural supports or unpaid supports – this language is in conflict with the federal HCBS regulations that define natural and unpaid supports as voluntarily provided, 41 CFR 441.301(c)(2)(5) 4.7 (g)(2)(J)(iii) Section on **HCBS.** ~~Community support hours may not exceed 25 hour per week~~. Community support hours shall be based on individual needs, based on assessment process. – 25 hrs / week for we/cs arbitrary - By putting 25 hrs in regs, people who work in office those in office – people need lots of supports at first – how to ensure professional workers have the support they need to get started in an advanced job	
1xFunding -continue as is – not as discretionary – use as has been done traditionally	
Before svs cut – go back to ICAR for this. ??? Purpose of having services adopted by rule is to allow the legislature to weigh in	
4.7(g)(2)(K) We recommend this be removed as housing safety and accessibility standards are defined in Department Guidelines. Service caps are included that we think should not be included. Only "physical accessibility" is addressed. Does this preclude resources being	

used for some accessibility needs such as auditory or visual?	
4.7(g)(2) (M) Places a cap on the amount of funding a person can receive. We recommend the caps be removed. DAIL funds individuals with lesser budgetary requirements in accordance with their support needs. We recommend that funding for all individuals be established according to their needs. Further, agencies are being required to serve these individuals without adequate funding provided and at a great loss to the agencies. I would like to suggest that the funding limits that are articulated in the System of Care Plan be increased to at least $350k. In addition, the funding limits and funding decisions must explicitly recognize that, in order to meet the needs of Vermonters, that there are situations where a particular Vermonter's needs require financial support above specified limits. A formal process to determine when and by how much any limit is exceeded must be explicitly described in the System of Care Plan.	
Section 4.7(g)(2)(0) This Section contains new caps on therapeutic visits and should be struck as the limits will potentially increase rates of institutionalization and/or serious mental health issues for individuals with disabilities. 4.7(g)(2) (O) Clinical services are capped for people. We question whether the caps are consistent with mental health parity laws. We also do not think clinical decisions should be made in this way, which may leave vulnerable people with inadequate care. The psychiatric care caps are not sufficient to meet the care needs of individuals experiencing periods of instability. Additionally, the regulations should not be a substitute for a physician determining medically necessary care.	

4.7(g)(2)(O) These therapeutic limits are shortsighted and will likely lead to increased institutionalization or serious mental health problems. This new language limiting the number of therapeutic visits should be deleted. 4.7(g)(2)(O) These therapeutic limits are shortsighted and will lead to institutionalization or serious mental health problems. There therapeutic limits also conflict with mental health parity laws. This new language limiting the number of therapeutic visits is all new and should be deleted. -96 hours below standard of care for clinical	
4.7(g)(2)(P) Funding for Facilitated Communication shall ~~only~~ be approved only when its use...spsc First and foremost my son deserves the right to communicate. Since Jacob is not able to express himself through the use of speech, he needs access to technology that will give him the opportunity to express himself for that on the fly communication as well as his expression. It was disappointing that Crotched used the excuse that "Vermont is cumbersome" in it's funding model for such devices. I hope the System of Care language can address this and not make it more challenging for individuals needing tools to communicate while in out of state placement and beyond. Additionally, I hope that the language for utilizing FC as one of Jacob's tools in his total communication is clear and concise. Jacob right to communicate through FC is very important to him. I included a few examples of his opinions in this regard. I think it is important to listen to his input and allow the method to continue as part of his plan both educationally and in the community buy having the language clear in the System of Care.	

Section 4.7 (g)(3)(i) This Section makes the use and distribution of One Time Funds subject to the discretion of the Department. Unless an alternative source of funding for unanticipated, short-term, and unusual needs is identified, this section should be struck. The annual distribution of One Time Funds to Vermont's Designated and Specialized Services Agencies cannot be discretionary. As is widely acknowledged, these funds are essential to Vermont's Designated and Specialized Services Agencies financial viability and their ability to deliver quality care in a cost-effective manner. One Time funds are typically used to address needs that are difficult to fund through other mechanisms within Medicaid and which if left unaddressed, have a high potential for triggering more costly services in the future. Therefore, these funds are essential to the health and safety of the Vermonters who receive services from a Designated or Specialized Services Agency. 4.7(g)(3)(i) The distribution of substantial One Time Funding to the designated agencies **must not** be discretionary. One Time Funding is essential to proactive supports and a functional system of care. This section must be re-worded to include: "These funds may *shall* be distributed to agencies at the discretion of the Department and are not guaranteed. The amount and timing of distribution is at the discretion of the Department." One-time funds must continue at their current level; they are essential to the health, safety, and well-being of Vermonters who receive services from Designated or Special Services Agencies. 4.7(g)(3)(i)	

The distribution of substantial One Time Funding to the designated agencies absolutely cannot be discretionary. Our system does not work if all of the One Time Funding was restricted or eliminated. This section must be re-worded to include: "These funds may *shall* be distributed to agencies at the discretion of the Department and are not guaranteed. The amount and timing of distribution is at the discretion of the Department." One-time funds must continue at their current level. 4.7(g)(3)(i) ~~These funds50% of these funds, at a minimum, shall (may) be distributed to agencies.at the discretion of the Department and are not guaranteed.The amount and timing of distribution is at the discretion of the Department.~~	
4.7(h) This specific service option, ICF/DD, should not be in regulation but if included should simply be identified as one of many service options that an agency may utilize.	
4.7(i) The Division apparently has more than one source of funding from which one-time funds are generated. Consequently, if this section is retained, we recommend it be separated into two sections: (1) One-Time Funds Generated from DS Caseload (New Appropriations and funds returned to Equity and Public Safety funding pools) and (2) One-Time Funds Generated from Various Sources other than DS Caseload as follows. *1) One time Funds Generated from DS Caseload. These are funds that result from providing agencies with only the amount of funds required to cover the number of days of service that will be provided during the fiscal year in which the funds are distributed. The funds that remain but are required to continue services for the individual in the following fiscal year are identified as "one-time." These one-time funds from caseload appropriated for the fiscal year and funds returned to Equity and Public Safety shall be distributed to agencies.*	

(2) <u>One-time Funds Generated from Various Sources other than DS Caseload.</u> One time funds are used to address short term needs and cannot be used for long term needs. These funds may be distributed to agencies at the discretion of the Department. The amount and timing of distribution is at the discretion of the Department. *The Division shall provide a report on how all one time funds were utilized to the Developmental Disability Services State Standing Committee within 120 days of the close of a fiscal year.* We recommend that the "Allowable Uses for One-Time Funding by Agencies and the Supportive ISO" be broadened to include things such as training. We also recommend that the caps be removed. Therefore, we recommend that these clauses be removed from regulations and defined in Department Guideline.	
4.7(j) We recommend that references to specific programs, SUCCEED, Think College and College Steps, be removed and the section simply reference Post Secondary Initiatives.	
4.7(k) We recommend that the limitations on hours be removed.	
4.7(l) We do not think this specific service program should be in regulations.	
4.7(n) We do not understand why one State Medicaid Plan coverage would be included but no others. Will other State Plan coverages continue to be available and if so, should they all be included?	
4.8 This section allows the Division to invest funds in initiatives. The funding stream for this should be identified. The process for the Division to secure stakeholder input and concurrence with proposed initiatives and the process for reporting back to stakeholders on the outcomes should be included in the clause. If other initiatives have eligibility criteria and limitations should this section too?	
Section 4.9 With respect to Approaches to Managing Within Funds, it is our opinion	

that 18 V.S.A. Section 8725 requires the Division, Department and/or Agency to go through the Legislative Committee on Rules process prior to reducing and/or eliminating services. This Section as it is currently worded should be struck. 4.9 We recommend this clause be removed from the proposed regulations. DAIL has consistently verbalized their recognition of the underfunding of the DS system. Approaches identified in this clause will further jeopardize people supported by the system and the capacity of agencies to maintain supports. If adequate funding is not available DAIL should seek support from the legislature. 4. 9 The Approaches to Managing Within Funds Available section must be cut. In the event of fiscal pressures the Division must go through the Legislative Committee on Administrative Rules prior to reducing or eliminating any services. 18 V.S.A. § 8725. 4. 9 The Approaches to Managing Within Funds Available section must be cut. In the event of fiscal pressures the Division must go through the Legislative Committee on Administrative Rules prior to reducing or eliminating any services. 18 V.S.A. § 8725 . 4.9 (a) Delete all. Replace with: Any change in the System of Care Plan to decrease services to individuals with Developmental Disabilities has to go through ALCAR	
CMS – need guidelines to assure conflict of interest in how guidelines ... getting information (IRA) that is not skewed.	
Limits and caps on services – 4.7.g.2.j – 25 hours limits, 4.7.g.2o therapeutic limit, and 8 hr day limit on self/family managing home supports – would like to have rational, but it contradicts s/f	

mgt section where it says they must manage all supports	
No where does it talk about non-payroll svs and supports (e.g,, safety connection) – innovative supports – how to fund them	
4.10 Since the 45 day criteria was established the funding process for individuals has been extended. Funding decisions used to be made by centralized Equity and Public Safety Committees and notifications of those decisions were usually made within two working days. Those committees now make recommendations to the Division. The Division has no timeframes for making and distributing their decisions which impacts the capacity of agencies to meet the 45 day time frame.	
4.11(a) Families have the option of choosing service options/providers outside of their geographic area but within the state system of care.spsc	
4.11 In (a) (1), we recommend that "full" be removed as it is not defined to allow for consistent interpretation. 4.11(a)(1) Heartbeet is pleased to see the proposed amendments to Section 4.11 (Choice of Provider), in particular the affirmative obligation in Section 4.11(a)(1) for Designated Agencies to provide service recipients with full information so that the recipient and his or her family are made aware of the choices of service options and providers, and the requirement for documentation to be made of the options discussed and the information shared with the service recipient.	
4.11 We recommend (a) (2) be revised to read: "If the recipient...that at least one agency within the geographic area offers the needed services at *the amount the DA requires to provide the service*." Funding must be provided at an amount that will allow the person's needs to be met. 4.11 Heartbeet recommends that Section 4.11 should be clarified throughout where it refers to another "agency" or another "provider", to make it clear that a recipient may choose to receive services with a non-agency provider (like Heartbeet) regardless of whether the non-agency provider is within the geographic region of a	

particular DA. This clarification will reflect the current reality that Heartbeet currently contracts with multiple DAs from around the State.	
Sec 4.11.a.3 does not mention shared management – need as many options explained by agencies – have it as real options. Have not maximized s/f mgt in Vermont – could be money safer but not with cap (Please also note that options at 4.11 do not include shared management.)	
4.11 We recommend (a) (3) be revised to read: If no other agency...the DA shall provide the needed services *at the amount the DA requires to provide the service and* in accordance with its Master Grant Agreement. We do not think (c) should be included in regulations; however, if included, it should be modified as follow: (c) – "The recipient may...services at or below the *amount required for the DA to provide the* *services."* (c)(1) – The last sentence should be modified to read: "If an alternative agency...the DA must *be funded and provide the services at the DA rate."* 4.11(c)(1), There is one specific instance where the "agency" - "provider" language needs to be clarified in Section 4.11(c)(1), where it states: "If an alternative **agency** is not able to provide the services at the lower approved budget, the DA must do so at that lower rate." The word "agency" should be replaced with "provider." (c)(2) – Agencies receive 5% administrative funding rather than their administrative rates. When they are required to transfer their full administrative rate, they are required to further add to their underfunding by sending more administration than they received. DAIL recently implemented a	

change so that agencies transfer the 5% administration that they received and not the additional amount they were required to internally fund. This change is not reflected in this section and needs to be incorporated. (c)(3) – The system provides funding to meet identified needs; however this clause implies that a person can shop for an agency that can provide the needed services at less cost; and consequently, receive more services than they were identified to need by taking their funding to the lower cost agency. This seems inconsistent with the intent of the system and efforts to be cost effective. It seems the excess funds should instead go to serve someone else as the person's needs could be met for less.	
35 – 4.11 – happy to see choice of providers – DA provide all options – this is good	
4.13(a) This section requires the use of the level of care assessment. Providers had been working collaboratively with DAIL to finalize this document; however, DAIL has not yet scheduled a meeting to complete this work. The tool should be finalized prior to inclusion in regulatory requirements.	
4.19(a) (5) What are PSEI funds?	
Part 5. Self/Family-Managed Services	
We currently family-manage services, and expected to continue to do that as our son transitions from school services. It has been great for our family. However the proposed rule reads like there will be nothing for us to manage except direct services. We will have to go through the agency for any other service, and for any funding request, and will also lose independent case management.	

Section 5 has comprehensive, yet no regs for home providers that have wrap services (JB notes on Karen Schwartz)	
Focus on caps to svs and make s/f mgt a reality in Vermont	
As a parent of two children on the spectrum, one on a Home and Community Based Waiver and one beginning to receive adult services, I find the changes proposed to be quite concerning. Prior to self-managing my daughter Sarah Dolney's med waiver, it was handled by the local agency. During this time period, I had a "set in stone" schedule. I had absolutely no say in who worked with my daughter. When I had a family emergency (I broke my ankle) it was not during the time that I was scheduled to have help. There was no help to be had, no exceptions. The agency did not help facilitate a resolution for this emergency, they only made the situation worse. The proposed changes in the regulations will not enhance or help my children. If anything, these changes will make things more difficult. At this time my daughter is still attending school. Under the proposed changes, I will not be able to fully manage my daughter's supports, I will only be able to manage a portion of these supports. I prefer dealing with the QDDP that I have chosen. Over the years that I have had to deal with the local agency, they were never on time with reviews, evaluations, etc. As a matter of fact, I very rarely heard from them or saw them. I am opposed to having to deal with my local agency due to past experience with the agency. By making more restrictions and whittling away at the choices, you will be creating hardships for families that already have a hard enough time making it from day to day. We have a very loving family and I know that it would be my son's choice to stay with his family, and I believe that he has that right. My daughter,	

who is non-verbal and in need of constant supports, I continue to believe that she has a right to stay with her family where she is loved and her care is of utmost importance. I do not believe that an agency with no vested interest in my child can make these decisions for them.	
41 s5.2 s/f mgt – responsibilities of person – not a big deal but it says that the ISA explains how much the services will cost on a weekly basis – should be monthly 5.2 (b) b. "The plan must specify what each service is supposed to be and how much the service shall cost on a monthly basis." In this sentence, recommend replacing "a monthly" with "an annual".	We agree to make this change.
Part d same section – minimum of 7 years – maintain records for perm audits – what is expected and would families need to pay back Medicaid funding 5.2 (d) Add "for a minimum of 7 years" to the end of the sentence "Maintain a complete and up-to-date case record that reflect details regarding the delivery of services."	Need to check regarding records retention requirements.
Vermont has never fully tapped and maximized the use of self and family management as an option. While the proposed regulations added some additional language here and there about options in reality the proposals eviscerate both the self/individual management AND shared management options by injecting an agency throughout. (See Part 5 and 10.6). The agency would control just about every aspect, from needs assessments to subcontracts with all providers except direct support workers. Under the proposed scheme independent service coordination will cease to exist since service coordinators will be agency subcontractors – in direct conflict with the federal Rule that requires conflict-free case management. The proposed regulations define self/family-management as managing ALL services (1.34). Yet, despite a robust, strengthened regulatory scheme that includes tools to address any problems that might arise, there is an arbitrary cap on home supports, forcing people to use agency services instead. (Part 5 and 4..7 (g)(2)(L). That is the opposite of providing people with a choice of options.	

People choose self/family management or shared management for compelling reasons. It allows people to maximize funding by providing an alternative to agency rates that include overhead. It also allows services to be provided more flexibly, when and where people need them rather than on an agency schedule. Following the federal Rule Vermont needs to expand these options rather than roll them back. There is also no provision for administrative expenses now reimbursable through self and family management (and which are incurred and should be allowed under shared management.)	
We are EXTREMELY happy with the family/self management option!!! This option has been a god-send!! And has made a HUGE positive difference in our daughter's life!! Our daughter is able to live as normal of a life as possible, with support, and able to determine what she needs/would like to do with support, rather than the agency. We very much appreciate our Supportive Agency and independent QDDP who are all available to guide and support us throughout this process. This option has made **all** of our lives richer and easier, especially our daughter's!! I can not emphasize this enough!!! The proposed regulations seem to *require* an increase DA involvement, which I hope is not the case. While an increase in DA involvement may be a good and important *option* for families and individuals, *requiring* this would be taking steps backwards....which we do NOT want to do!	
Our family was one of the first families to self/family manage. My son experienced severe brain-injury from birth. He lived with us here at home until his passing 2.5 years ago at 35. I started the self management journey with my son with a lot of questions and not a little doubt about how this would work. Once we started I would never have gone back. We used a Unified services Plan because Zachary also had a High Tech	

Waiver because of his intense medical needs. The Nursing company was failing at keeping our night time coverage qualitative or consistent. With our ability to combine these HCBWaiver and the HTWaiver. We were able to pay our staff a livable wage and offer a benefit of paid leave time ,until that was taken away. It appears that some of the current proposed changes would limit choices for families, in opposition to the federal home and community-based rules. I, also, have been an Independent Service Coordinator and a QDDP since 2005,for a few families. Right now I do this for 4 families and individuals. It would appear according to the wording of the changes that I would only be able to continue this work if there is an affiliation with an agency, and the agancy would be doing the yearly assessment. All of my families no longer want anything to do with their local DAs. I fail to see how this gives "choice". The "system" continues to whittle away at the pieces of this program to help families stay together. As a former member of the "Self Determination Project" here in VT I understand individuals rights and advocate for those individual rights to be first and foremost, but some people just want to live in a family that supports and loves them. That choice is also a right. I would encourage you to keep these choices available to all people with disabilities and not limit families.	
The workgroup had diverse and sometimes conflicting perspectives on this section. Specifically, the roles, responsibilities, informed ISA development, training, confidentiality, and reporting requirements of the Department, DA, SSA, Supportive ISO) need to be reconsidered. Draft Section 10.6(b) requires the Department to verify that non-designated entities meet quality review standards. Highlighting the active role of families in managing and overseeing services is important on principle and in practice. The existence, role, and responsibilities of the Self and Family Managed Services Program	

Funding Committee was not included in these rules.	
Self/Family-Managed Services. The workgroup had diverse and sometimes conflicting perspectives on this section. Specifically, the roles, responsibilities, informed ISA development, training, confidentiality, and reporting requirements of the Department, DA, SSA, Supportive ISO) need to be reconsidered. Draft Section 10.6(b) requires the Department to verify that non-designated entities meet quality review standards. Highlighting the active role of families in managing and overseeing services is important on principle and in practice. The existence, role, and responsibilities of the Self and Family Managed Services Program Funding Committee was not included in these rules. **Section 5.3, Role, was especially concerning to all constituents. No recommendations were agreed to by this workgroup.** Among the concerns voiced were that having the Designated Agency Funding Committee responsible for putting forth proposals to the Equity Committee for changes in funding would remove these decisions from the entity most knowledgeable about the individual and their needs. Currently, with the family or individual managing the services, the ISO plays the role of technical assistance. The self-management advisory committee reviews requests for changes in funding, and creates the proposal to the Equity Committee, with assistance from the ISO. For many individuals and families who have elected to to take on the hard work of self-managing, the	

reason for this decision may have been difficult relations with the DA. This proposed rule change may undermine the self-determination they are attempting to exercise. At the same time, the people most concerned about this rule change acknowledged it would be useful for the ISO and the self-management advisory committee to have additional training on constructing and making decisions about funding proposals. spsc **5.3 Role of the Designated Agency** Recommend replacing proposed language for existing recipients with the following: For existing recipients who are self /family-managing who need an increase in services and funding, the Supportive ISO will perform a needs assessment, develop and present a finding proposal to the Self/Family-Management Funding Committee prior to requesting funding at the statewide funding committees. For complicated circumstances, the Supportive ISO may consult with the local Designated Agency to determine strategies regarding how an individual's needs may best be met. This may include a collaborative effort between the Supportive ISO and DA regarding assessments and funding proposals as needed. (Kara) In complex situations, the Provider may seek additional expertise in conducting an assessment of need, including requesting assistance from the Designated Agency, an independent clinician or other evaluators with relevant expertise. (Kara referenced the T-II provider agreement language which is slightly different from her comments – I e-mailed her to reconcile)	
Pg 44 5.4 – role of QDDP – person needs to be employed by an agency – add language of division endorsement of independent QDDPs	

5.4(b) If a QDDP is working for an agency, it would be a shared managed situation versus a self/family managed situations. 5.4 (b) Recommend changing second sentence to "Before a person uses a QDDP, the Department's endorsement is required to ensure that they have the knowledge and skills to perform the duties of a QDDP".	
45 5.5 – responses of S-ISO – section d – wording that needs to change – "help the person to develop and directly managed the AFL" – but not have it sound like TII is managing—instead provide guidance in managing the funding limit (get wording form Kara) 5.5 (d) d. Help the person to develop an authorized funding limit (AFL), provide guidance in self-managing the AFL, ensure the AFL is not managed by a third party, as well as, provide assistance in determining whether a service is reimbursable under Department rules. Provide the FE/A with the person's AFL. (Kara)	Yes, make this change.
5.5 (e) Recommend changing language as follows: "Bill Medicaid the daily rate approved by DAIL and reconcile unspent funding at year-end.	
5.5 (i) Recommend adding "records must be retained for a minimum of 7 years."	
5.7 Is there clarity in the proposed regulations that shared managed services do not involve the Supportive ISO?	
Sec N – advisory board is actually a committee 5.5 (n) Recommend replacing "board" with "committee."	OK
The clarity that was added to this section was well done	

Parent who self-manages objected to the change regarding the role of the DA in self-management. Looking to move T-II making recommendations for funding changes. Would not want to have to go back and work with the DA when it has not been successful for the family in the past.	
TII – here to talk about role of DD – moving from TII making assessment to DA making decision. Concerned about the DA making decisions about my son – why I moved away from DA – also made written comment. Also – the 18 and 19 year-old change, but he is 18 now and am in support of it moving to age of adult which is 18.	
Part 6. Recipient financial Requirements	
Part 7. Special Care Procedures	
7.2a People who provide special care procedures have the training, and monitoring they need to protect the health and safety of the people they are responsible for. Language in this section, especially regarding nursing, appeared to be inconsistent. The workgroup suggested that the Department ask the Office of Professional Regulation (OPR/Board of Nursing) to review staffing in this section.	
Section 7.7 and 7.8 This Section permits certain training and competence determinations for Specialized Care procedures to be provided by non-Registered Nurses. The training received by a Registered Nurse is essential to ensure that the persons authorized to provide special care procedures have the requisite professional competence. 7.7 and 7.8 Training and determination of competence for Specialized Care procedures must be done by a registered nurse instead of an LNA. The training	

and expertise of RN's is critical for ensuring the appropriate level of competence to perform special care procedures. 7.7 and 7.8 Training and determination of competence for Specialized Care procedures must be done by a registered nurse instead of an LPN's. No disrespect to LPN's's but the training of RN's is vital for ensuring that persons authorized to perform special care procedures have sufficient competence.	
7.7, 7.8, 7.9 and 7.10 Registered is removed before nurse in all these clauses. Nurse is not defined in Part 7 or in the definitions in Part 1, and a definition needs to be added to the regulations. Required nursing qualifications are unclear. The inference is that a Licensed Practical Nurse may now do these tasks rather than a registered nurse. We are, however, confused by that inference as we know the State secured additional funding to support the hire and retention of registered nurses in State government, in particular at the Vermont Psychiatric Hospital. Do the tasks of training and delegating the special care procedures outlined in Part 7 require lesser nursing training than that required by nurses working for the State?	
Part 8. Grievance, Internal Appeal and Fair Hearing	
We recommend that Part 8 - Grievance, Internal Appeal and Fair Hearing be removed from the regulations and the requirements be conveyed through Guidelines. It is our understanding that the Agency of Human Services will soon have to update this policy to comply with changes made when the 1115 Waiver recently renewed. As such, by retaining this policy within these regulations, the DD Act Regulations will likely need to be updated within a few months of approval. We recommend that these guidelines also be formatted to make them more accessible	

and usable to constituents, particularly those with cognitive impairments.	
8.4(a) The explicit extension of the timeline for extension of an appeal is a good addition. In our experience, agencies are not uniformly and consistently providing proper notice of adverse actions. 8.4(a) The explicit extension of the timeline for extension of an appeal is a good addition. In our experience, agencies are not uniformly and consistently providing proper notice of adverse actions.	
Part 9. Training	
Throughout this section include the wording: best and promising practices and the priorities of the System of Care Plan.	
Values – Respect – need objective criteria to make sure person's rights are actually respected. People are often in a situation where their rights are curtailed.	
9.3 This section is identified as "Agency Responsibilities;" however, we think it should be identified as *Agency and Supportive ISO Responsibilities*. A number of new training requirements are added to the regulations. We appreciate the support of positive philosophical approaches; however, the addition of new requirements, must have funding attached to support implementation. Agencies cannot be expected to comply with new requirements without additional resources. 9.3 This person-centered values list is very good, and reminds us how much we appreciate the regulations for codifying this perspective.	

9.3 This person-center values list is very good, and reminds us how much we appreciate the regulations for codifying this perspective.	
9.4 The first sentence of this section adds "and demonstrate knowledge" as a new criteria. We do not know what this means and recommend definition as follow: and demonstrate knowledge *through post training testing* in all the following areas:	
9.4(c) and 9.5(a) (2) These sections add a requirement that the agency ensure "that the employer of record has provided training and the worker demonstrates knowledge" in specified areas. The agencies do not have a relationship with these workers who are employed by others. This is a decision the system made and has continued to preserve as a cost saving method of providing services. The responsible employers are families or home providers. As such agencies cannot take on this role. If this is a practice that DAIL wants to implement, we recommend that the State look to take on these responsibilities through their relationship under the home care worker union agreement. However, for consistency, we recommend DAIL approach this as they do for people who self/family manage. In those situations, the Supportive ISO is not responsible, the employer of record, the individual or their family, is simply responsible for providing the training.	
Section 9.6(b) This Section provides too many exceptions to essential quality protections in the event of an emergency. Further, 4 days (96 hours) is too long a time period in which to allow certain quality and safety requirements to be suspended. The root causes of staff turnover and vacancies, including the lack	

of livable wages, must be addressed at the systems level. 9.6(b) The list of exceptions for emergencies is problematic and presents quality and safety challenges. "Emergencies" and "Unavailability of paid care" are unfortunately becoming code for insufficient compensation of direct care staff and the resulting turn-over and vacancies in staff positions. 9.6(b) The list of exceptions for emergencies if problematic. There is insufficient training for workers codified here. "Emergencies" and ""Unavailability of paid care" are unfortunately becoming euphemisms for direct care staff not getting paid enough, and turn-over and vacancies in staff positions.	
Part 10. Certification of Providers	
Certification equals designation as contained in 10.2a and 10.2c. 10.2 (b)(c). Do these sections make sense? Is just 10.2a needed? spsc	
10.2(f) The approaches in this section are not currently in place if indeed the intent of this Part is to address recertification as well as initial certification. Written determinations are not available within 30 days and Master Grant Agreement execution has not guaranteed that a grant agreement is timely in place.	
Section 10.5 This Quality Standards for Services set out here are weaker than the current standards. The current standards should either be strengthened or maintained. In no event, should the Quality Standards for Services be	

weakened, as this would work against the legislative intent of revisions to 18 V.S.A. chapter 204A §8725 under Act 140 (2014). 10.5 The previous Quality Standards for Services language was much stronger and more specific; it should be restored. Under no circumstances should we weaken quality. 10.5 The previous Quality Standards for Services language was much stronger and specific and should be restored. The new language is weaker. 10.5 Is this redundant? Can it be omitted?	
As I testified at the hearing, the evaluation process should not rely on subjective "feelings", but must look at objective findings to determine whether people's civil rights are protected and respected, and whether services and supports are benefit people. (10.5)	
In reviewing the proposed rules I draw most attention to the language pertaining to issues of QDDP, Agency Certification and ISAs. As you can see in my emails below I have detailed that the Certification of Agencies is very important in that we need to assure that agencies are serving the needs of clients as #1 priority and to do so most effectively and with the least amount of administrative cost. I step beyond the definition of Agency Certification and I propose we need to have Certified Case Managers. I believe this strongly as is seen in my email below dated 12-29-16 and 12-26-16 to Julie Tessler I assert the need for Client Centered service provision and this from Plans developed with Case Managers. A Case Manager Certification would assure that ISOs/Plans are developed with client/consumer and their significant others which would likely include: guardian, family members and home provider.	

I draw a strong argument that individualized plans need to be fully attentive to the developmental needs of our clients/consumers and I cite the proven theory of the Hierarchy of Needs from Abraham Maslow-Theorist as evidence of this proven approach. Basically we need to assure that Plans are developed with our clients/consumers that address their state goals as it pertains to community engagement and this includes quality of life issues as well as vocational interests. a Certified Case Manager would benefit our system in that it would over time decrease the amount of cost associated with Administrative and Management within agencies. Certified Case Managers would have increased autonomy and the ethical duty to provide Client Centered Plans with less need for supervisory functions. We can develop a more streamlined process of reporting to DAIL the outcomes of Plans and the process of quality assurance can be made less cumbersome with communications from agencies to DAIL on Plan (ISAs) evaluations periodically done. The issue of supervision of Certified Case Managers is made much less expensive. In fact we could have a Peer Supervision process whereby CCMs would be required to do Peer Supervision for no cost and it would be a requirement for re certification. Re certification can be done at perhaps every 5 years. I am fairly confident that a Certification process can be adopted either through existing Case Management Certification entities such as the CRCC: Commission for Rehabilitation Counselor Certification or can be developed here in Vermont with the multitude of professionals familiar with the needs of our clients. I would believe that training and coursework could be accessed through our local college systems or through the existing training entities already utilized by our agencies. I have had discussions with Joshua Smith at GMSS and Jeff Coy of DAIL on this perspective which was met with open mindedness and however we scratched our heads on how this could be done. I believe if a Certified Case Manager role is valued then we will find a way to get it done. Like anything else we will find a way with persistence.	

I advocate for a system of care that holds as #1 priority the provision of services to client/consumer. I believe we need to use any cost savings from decreased administrative cost to put into increased service to clients/consumers. I believe in the Certified Case Manager model as a means to assure ethical obligation to serve client and engage client and their significant others: including home providers in Plans developed that are developmentally accurate and meet interest and needs expressed by client.	
10.6 Heartbeet is also pleased to see the addition of new Section 10.6 which formally recognizes that there are non-designated developmental disability service providers. Perhaps the Section should be renamed to "Services by non-designated providers." Beyond the semantics of the section name, Heartbeet is greatly concerned about the inclusion of the following sentence in Section 10.6(a): "The decision to subcontract with an entity or organization is at the discretion of the agency." This language is not consistent with the Developmental Disabilities Act which says in Section 8724(6) that the Department is supposed to provide service recipients with "meaningful choices about how they live and the kinds of services they receive." The proposed language of Section 10.6(a) is also in conflict the proposed changes to Section 4.11 of the Rules (Choice of Providers).	
10.6 (a) Section 10.6(a) should be revised to make it clear that as long as the non-designated entity or organization is operating in compliance with all applicable state and federal law, rules and policies, and that non-designated service provider can provide the "needed services at or below the authorized funding limit" (as required under Section 4.11(c)(1)), then decision to subcontract with a non-designated provider should be **at the discretion of the recipient,** and not the agency.	
Part 11. Evaluation and Assessment of the Success of Programs	

Kennedy, Alice

From: Hutt, Monica
Sent: Monday, January 08, 2018 1:23 PM
To: Mohlman, Mary Kate
Cc: Hill, Bard; McFadden, Clare; George, Camille
Subject: DRAFT.Delivery System Report 1.8.18.docx
Attachments: DRAFT.Delivery System Report 1.8.18.docx

Mary Kate, I didn't have a lot of time today but I know that you are on a deadline for this report. I did add some thinking and made a few edits, particularly in the DAIL section. Perhaps Bard, Camille or Clare can contribute a bit more but I wanted to get my thoughts in in a timely fashion. Thanks, Monica

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The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

VERMONT
AGENCY OF HUMAN SERVICES

Report to the Vermont Legislature

Delivery System Reform Report: 2017

Act 113, Section 12; Act 82, Section 7

Submitted by the Agency of Human Services to Senate Health and Welfare, House Health Care, House Human Services.

1-15-2017

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REPORT REQUIREMENTS

Act 113, Section 12 of the 2015-2016 Session requires the Secretary of the Agency of Human Services to embark upon a multi-year process of delivery system and payment reform for Medicaid providers that is aligned with the All-Payer Model and other existing payment and delivery system reform initiatives.

FULL TEXT:

(a) The Secretary of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all Medicaid payments to affected providers and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives.

(b) On or before January 15, 2017 and annually for five years thereafter, the Secretary of Human Services shall report on the results of this process to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services. The Secretary's report shall address:

(1) all Medicaid payments to affected providers;

(2) changes to reimbursement methodology and the services impacted;

(3) efforts to integrate affected providers into the all-payer model and with other payment and delivery system reform initiatives;

(4) changes to quality measure collection and identifying alignment efforts and analyses, if any; and

(5) the interrelationship of results-based accountability initiatives with the quality measures in subdivision (4) of this subsection.

Section 7 of Act 82 of the 2017-2018 legislative session requires a plan to integrate multiple sources of payment for mental and substance abuse services to the designated and specialized service agencies (DAs and SSAs).

FULL TEXT

Act 82, Sec. 7. PAYMENTS TO THE DESIGNATED AND SPECIALIZED SERVICE AGENCIES

The Secretary of Human Services, in collaboration with the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living; providers; and persons who are affected by current services, shall develop a plan to integrate multiple sources of payments for mental and substance abuse services to the designated and specialized service agencies. In a manner consistent with Sec. 11 of this act, the plan shall implement a Global Funding model as a successor to the analysis and work conducted under the Medicaid Pathways and other work undertaken regarding mental health in health care reform. It shall increase efficiency and reduce the administrative burden. On or before January 1, 2018, the Secretary shall submit the plan and any related legislative proposals to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services.

This is the second annual report. The first annual report submitted detailing progress on delivery system and payment reform for Medicaid providers can be found here:

- First Annual Report Filed 1/3/2017: http://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-12-Medicaid-Pathway-Report-12-30-16.pdf

EXECUTIVE SUMMARY

2017 was an exciting year for payment and delivery system reform in Vermont. One of the more significant steps Vermont took was launching a first in the nation pilot payment model where a network of hospitals and providers took on the fiscal responsibility for the care and health of their patients. While this pilot was limited to Medicaid patients, it laid the foundation for expanding this risk arrangement to Medicare and commercial insurers, which is currently underway in 2018. Taking on fiscal responsibility for the health outcomes of patients calls for better coordination of care, more emphasis on prevention, and the necessary bridging of services across the care continuum to accomplish the first two goals.

Medicaid as a payer has an integral role in shaping payment reform and supporting delivery system reform. Under the authority of the Global Commitment to Health, the Medicaid 1115 waiver that gives Vermont additional flexible in the way it uses its Medicaid resources, Vermont has pursued new payment mechanisms, covered services not traditionally reimbursable through Medicaid, and implemented programmatic innovations such as Blueprint for Health, Hub and Spoke, and Choices for Care. As Vermont continues to build on its previous successes in health care reform, AHS, through its constituent departments, has prioritized shifting from fee-for-service, which incentivizes volume of care, to value-based payments and care, which emphasize better health outcomes and sustainable costs. In addition to the Medicaid risk-based pilot, AHS has partnered with the accountable care organization OneCare Vermont to develop improved care coordination and integration of services, and the Department of Mental Health is developing alternative payments for services provided to children and to adults.

As part of this process, AHS recognizes that the success of payment and delivery reforms relies on a strong foundation. This solid foundation must include equitable payments, accountability for the services rendered, and data by which the first two can be supported and assessed. AHS has taken steps around payments by increasing reimbursement rates for primary care, reconciling in-state and out-of-state hospital rates, and realigning Federally Qualified Health Center payments with federal law. Regarding accountability, AHS, and specifically the Department of Disabilities, Aging, and Independent Living, are working to improve the accounting of payments paid and services delivered within the developmental services system. Knowing the actual costs of the services and having sufficient information to ensure the quality of the services are important precursors to reforming how AHS pays for the services. Finally, AHS is working to improve how data is collected and managed across the Agency through a new governance system.

Act 113, Section 12 requires the Secretary of the Agency of Human Services, in collaboration with the Director of Health Care Reform and the Green Mountain Care Board to create a process for payment and delivery system reform for Medicaid providers and services and to report on these activities. Act 82, Section 7 asks the Secretary of the Agency of Human Services, in conjunction with Commissioners of the Departments of Mental Health and Disability, Aging, and Independent Living to submit a plan for reforming payments made to the designated agencies and specialized service agencies for mental health and substance use disorder services. The Agency believes that the content of the Act 82, Section 7

report falls within the payment and delivery system reforms requested in Act 113, Section 12, and therefore has been integrated into this report.

The following report, ~~servicing~~ serving as the second annual report required by Act 113, Section 12, reviews in greater detail the progress the AHS has made towards shifting to value-based payments, improving integration across the continuum of care, and improving accountability.

SECTION 1: INTRODUCTION

The year 2017 brought substantial transition for state government in general and health care reform specifically. In additional to a new Administration and significant leadership change in the General Assembly, Vermont embarked on the implementation of two new agreements and the extension of a third:

1) The Vermont All-Payer Accountable Care Organization (ACO) Model Agreement (APM Agreement) with the Centers for Medicare and Medicaid Services (CMS);
2) A Medicaid contract with OneCare Vermont ACO LLC (OneCare), which established a pilot Next Generation ACO model for approximately 29,000 Vermont Medicaid beneficiaries; and
3) The Global Commitment to Health Medicaid 1115 Waiver, which gives Vermont the ability to be more flexible in the way it uses its Medicaid resources such as new payment mechanisms, coverage of services not traditionally reimbursable through Medicaid, and programmatic innovations.

Through these agreements, Vermont has the opportunity to shape how we pay for and deliver health care in way that is tailored to Vermont needs and improves alignment across payers, including Medicare, Medicaid, and commercial insurers. Collectively, these efforts have the goal of better health, better quality care, and affordable and sustainable health care costs. Furthermore, the changes in payment for and delivery of care that Vermont is pursuing creates incentives to focus on primary and preventive care and to create more alignment between medical, mental health, substance use disorder, and social services. These reforms recognize that health is not limited to the doctor's office, but begins where we work, play, and live.

Under the previous administration, efforts began to introduce payment and delivery reforms to Medicaid-funded programs, including services provided by the Designated Agencies (DA's), Specialized Service Agencies (SSA's), and preferred providers of substance use disorder services. This work occurred through the Medicaid Pathways initiative, which was launched by the Agencies of Human Services (AHS) and the Agency of Administration (AOA) in the Fall of 2015. However, under the incoming Scott Administration, the focus for 2017 shifted to establishing the Vermont Medicaid Next Generation (VMNG) ACO pilot model and to prepare for expanding ACO-based reform to Medicare and commercial insurers as well and expanding the number of hospitals, providers, and Vermonters engaged. Furthermore, while a report produced by Burnes and Associates for the Medicaid Pathways project reviewed multiple payment reform models for DAs and SSAs, it also identified a number of challenges that currently incumber implementation. For example, payment reform for DAs and SSAs would benefit from standardization around data quality, consistency, and collection; standardization in reimbursement

and billing guidelines; and better readiness for operationalizing reforms. [cite] As another example of the current challenges to payment reform, a 2014 report by the State Auditor on DA and SSA budgets [cite] found insufficient data on developmental disability services to confirm whether services paid for through inclusive payments were actually delivered to the individual. While this finding should be addressed regardless, it also has significant impacts on payment reform. Successful payment reform cannot proceed without parties involved having a clear understanding of the actual services being delivered, an accurate cost of these services, and the quality of the services. A current review by DAIL of service delivery, accountability and reporting mechanisms~~this by DAIL~~ is currently underway.

Despite these challenges, AHS, using the lessons learned through the Medicaid Pathways process, continues to pursue the goals of a more integrated health care system across the care continuum and the creation of value-based payments. These pursuits are in-line with AHS's strategic goals [is there something to cite?] and responsibilities under the APM Agreement. In addition to efforts at the state level, OneCare's recently approved budget for Year 1 of the agreement also supports a care model that integrates care across multiple organizations and employs alternative payment mechanisms.

The following report outlines 2017 work that occurred to support payment and delivery system reform with the goal of a more integrated health care system.

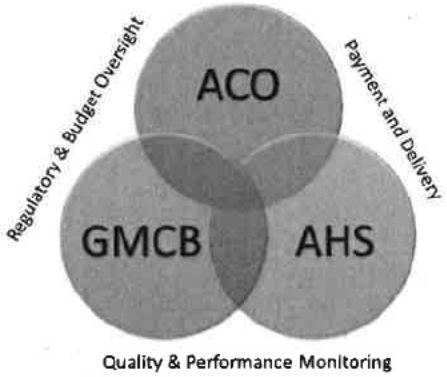
SECTION 2: ACO-BASED REFORM

While AHS would likely pursue Medicaid payment reforms that incentivize increased integration and alignment across the care continuum and have the goals of high-value care and sustainable health care costs, the APM Agreement and ACO-based reforms are the current vehicles through which these reforms occur. As such the priority for 2017 has been to operationalize the provisions of the APM Agreement.

ROLES AND RESPONSIBILITIES UNDER THE APM AGREEMENT

The APM Agreement identifies AHS and GMCB as the key state entities charged with carrying out the responsibilities laid out in the agreement. Specifically, GMCB is tasked, in collaboration with AHS, with monitoring how the model is achieving financial, quality, and outcome targets. The General Assembly, through Act 113, supported this role by granting GMCB regulatory authority over ACOs including approval of their budgets. AHS, in collaboration with GMCB, is tasked with creating the conditions in which the ACO can begin to improve coordination across the care continuum. The ACO accordingly has the role of engaging multiple payers (i.e., Medicare, Medicaid, and commercial insurers) to establish alternative ways of paying hospitals, medical providers, and community providers. Figure 1 describes these relationships.

Figure 1. Key Relationships under the APM Agreement



Additional Actors: Legislature, Centers for Medicaid and Medicare Innovation, Medicare, Medicaid, commercial insurers

VERMONT HEALTH CARE REFORM

To carry out the responsibilities under the APM Agreement, AHS Central Office, DVHA, including Blueprint for Health, and GMCB meet regularly to review how respective activities are aligning, for example, how progress on developing the VMNG contract coordinates with GMCB's review of the ACO budget. Additionally, AHS staff and Commissioners of the Department of Disabilities, Aging, and Independent Living (DAIL), Department of Mental Health (DMH), Vermont Department of Health (VDH), and Department for Children and Families (DCF) meet with OneCare regularly to review how OneCare's delivery system reforms align with AHS services. Examples agenda items include screening tools used, quality and performance measures, LTSS, etc. GMCB works with OneCare in its oversight capacity to ensure the ACO is meeting its requirements for certification and operates in compliance with its budget order.

Finally, an agency-wide group met regularly in the first part of the year to review how the work in each of the departments in AHS intersect with the other departments and with the health care system. This group provided valuable level-setting around AHS services and identified common themes across departments. One of these themes was the continual struggle to capture acute care or service dollars and invest them in preventive services that could avert the need for expensive acute care down the road. One of the goals for payment reform is to address this concern. Moving forward, this cross-agency group will work to ensure that AHS fulfills its role in the APM Agreement in a coordinated way.

APM EXPECTATIONS FOR ALIGNMENT AND INCLUSION OF ADDITIONAL MEDICAID SERVICES

The APM Agreement's initial focus is on hospital and physician services. DVHA's VMNG ACO Pilot program with OneCare was the first step in operationalizing the goals and provision of the agreement. In 2018, OneCare has extended the VMNG another year, is including Medicare and BlueCross BlueShield of Vermont (BCBSVT), and expanding to additional communities. However, the APM Agreement also calls out the need to include other services necessary to achieve the population health and quality outcomes over the period of the agreement. These services include mental health, substance use disorder, home- and community-based services, and long-term institutional services. The agreement also calls for close

monitoring to ensure the ACO is investing in community-based services such as Blueprint for Health community health teams and preventive services.

Expanding services will involve strategic planning in collaboration with OneCare and GMCB. By December 31, 2020, the state must have developed two plans: one involves coordinating financing and delivery of Medicaid mental health and substance use disorder services with the APM Agreement financial and quality targets; the second involves coordinating the financing and delivery of Medicaid home- and community-based services with APM Agreement targets. Beginning on January 1, 2021, Medicaid Long-Term Institutional Services will be included in the APM Agreement as financial target services.

While these deadlines are still a couple years away, initial planning and preparation has already begun. These efforts are summarized in Section 3.

DELIVERING COORDINATED, HIGH-VALUE CARE

In the Medicaid Pathways project, much of the work was guided by the following principles, which made up the Vermont Model of Care:

1. Person /Family Centered and/or Directed Services and Supports
2. Access to Independent Options Counseling & Peer Support
3. Involved Primary Care Physician (PCP)
4. Access to Specialized Services
5. Lead Care Coordinator (Single Point of Contact)
6. Medical Assessments and Disability and LTSS Screening by PCPs, Medical Specialists
7. Disability and Long-Term Services and Support Specific Assessments
8. Comprehensive Care Plan (including a Shared Care Plan)
9. Individual Care Team (ICT) and Care Conferences
10. Support During Care Transitions
11. Use of Technology for Information-Sharing

Prior to the Medicaid Pathways, Integrated Community Care Model (ICCM) Learning Collaborative, which established many of the above principles, was launched in 2014 by Blueprint for Health, GMCB, the three ACOs, and VHCIP staff with support from VHCIP funding. The ICCM Learning Collaborative brought in experts from across the country to work with Vermont organizations to systematically identify individuals and families who would benefit from cross-organization, team-based care. The Learning Collaborative also supported a common set of tools to engage people in their care, brought together providers working with each identified patient in patient-centered teams, developed shared-care plans based on the patient's goals and abilities, and supported communication among team members for more complete, effective, and efficient care and better patient outcomes. Communities used existing local infrastructure including project managers, quality improvement facilitators, and community health teams to support the model.

The ICCM Learning Collaborative has served as the foundation for the care model currently used by OneCare. This care model uses data to identify health risks across the population, dividing people into

four progressively more intense levels of care, implementing community wide prevention strategies, supporting self-management of health conditions, and proactively targeting services to individuals who need them most. In support of the care model, OneCare has implemented a payment structure that supports team-based care, share care plans, and a lead care coordinator. For more information on OneCare Vermont's population health initiatives and payment reforms, see provisions 29-43 in the GMCB's FY18 Accountable Care Organization Budget Order.[include citation/link]

As part of the collaboration between OneCare and AHS, departments have begun to explore how their services align with the Care Model and how to improve coordinated services.

Around the same time the ICCM emerged, VHCIP funding supported a new model of collaborative leadership for population health improvement work, called Accountable Communities for Health. Like the ICCM work, the first step was a year-long learning collaborative. The Accountable Communities for Health Learning Collaborative engaged management- and leadership- level staff from across the spectrum of health care and community service organizations, including mental health, substance use disorder treatment, home health, aging services, food banks, housing organizations, transportation companies, and more. The participating groups from each community often emerged from the Community Collaboratives that are supported by the Blueprint for Health, ACOs, and the Vermont Department of Health. The Accountable Communities for Health Learning Collaborative gave these groups an opportunity to develop or refine their work in nine core areas: Mission, Multi-sectoral Partnership, Integrator Organization, Governance, Data and Indicators, Strategy and Implementation, Community Member Engagement, Communications, and Sustainable Financing. Many Community Collaboratives found this framework so useful that they formally adopted it as their strategy for improving the health of the population in their region. Some have also begun calling their Community Collaboratives "Accountable Communities for Health." These multi-disciplinary population health leadership bodies guide and monitor improvement work in their communities related to care management, prevention and healthy living initiatives, self-management programs, cross-organization clinical quality improvement, substance use disorder and mental health services, and other locally-determined priorities.

SECTION 3: 2017 DEPARTMENTAL REFORM INITIATIVES

CMS RECOGNITION OF 7 NON-FEE FOR SERVICE PAYMENT MODELS

One of the goals of implementing the Global Commitment to Health demonstration is to improve the health status of all Vermonters by promoting delivery system reform through value-based payment models. As per the Special Terms and Conditions of the currently approved Global Commitment to Health Medicaid 1115 waiver demonstration, AHS must submit certain non-fee-for-service payment models to CMS for approval prior to implementation. To ensure consistency with the state's health care reform vision, all proposed payment models must advance at least one of the goals and objectives in the Global Commitment to Health Comprehensive Quality Strategy (CQS) and use a common set of performance measures across all providers.

During negotiations to extend the Global Commitment to Health waiver in 2016, Centers for Medicaid and CHIP Services (CMCS) and Vermont recognized that the Vermont Medicaid program has made

efforts under its demonstration to implement delivery system and payment reforms. Both parties then performed an inventory of payment models that are authorized through the waiver and outside of the Vermont Medicaid State Plan. As a result of the inventory, CMCS and AHS identified 7 existing non-FFS payment models for future review and approval by CMCS:

1. Vermont Medicaid Next Generation ACO
2. Blueprint for Health- Patient-Centered Medical Home
3. Blueprint for Health- Community Health Teams
4. Blueprint for Health- Women's Health Initiative
5. Dental Incentive Payment
6. Children's Integrated Services
7. Integrating Family Services

These models demonstrate progress through the Vermont Medicaid program to implement alternative payment model approaches that are supportive of delivery system reform. Each of these payment model applications were reviewed to ensure that they were representative of the array of services provided and of the diversity of individuals served as well as aligned with the broader demonstration goals and objectives. As of the date of this writing, all payment models have been approved by CMS.

DEPARTMENT OF VERMONT HEALTH ACCESS

PROGRESS ON VERMONT MEDICAID NEXT GENERATION ACO PILOT PROGRAM

The VMNG ACO pilot, as one of the approved payment reform models, represents the initial phase of Medicaid's participation in the integrated health care system envisioned by the APM Agreement. In February of 2017, DVHA contracted with OneCare to launch the VMNG Pilot program for the 2017 calendar year with four optional one-year extensions. The model's goal is an integrated health care system with incentives aligned to improve quality and reduce unnecessary costs. The VMNG ACO Pilot program pursues this goal by transitioning how we pay for care from fee-for-service payments to value-based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

Through the VMNG Pilot program in 2017, DVHA partnered with OneCare to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. OneCare's network of participating providers includes the University of Vermont Medical Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital along with their employed physicians and providers. It also includes two Federally Qualified Health Centers; independent practices; home health providers; Designated Agencies; Area Agencies on Aging; and skilled nursing agencies in the four participating communities.[1] Together, DVHA and OneCare are piloting a financial model designed to support the clinical and operational capabilities of the ACO provider network with the goal of supporting health care professionals deliver the care they know to be most effective in promoting and managing the health of the population they serve.

[1] See https://www.onecarevt.org/NetworkParticipants.

The VMNG ACO Pilot program was designed to support the implementation of Vermont's APM Agreement. Most notably, the included services, attribution, and payment methodologies are aligned with the Medicare Next Generation ACO program, including all-inclusive population-based payments. Through the VMNG, DVHA pays OneCare a monthly per member fixed prospective payment for services closely corresponding to Medicare Part A and Part B services that are provided by hospitals (and hospital-owned practices) participating with the ACO. The OneCare is responsible for both the cost and quality of care for each attributed member, regardless of how much care that person uses. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. Beyond payment, the majority of quality measures align with the APM Agreement. In accordance with Act 25 of 2017, DVHA submitted updates on the VMNG ACO Pilot on June 15, September 15, and December 15, 2017.

DVHA and OneCare elected to exercise one of the four optional one-year extensions permitted by the VMNG contract. A one-year extension enables DVHA and OneCare to continue the program for the 2018 calendar year. DVHA and OneCare highlighted several mutual goals for a 2018 performance year when entering into negotiations:

- Minimize programmatic changes from 2017 to 2018 to provide stability for ACO-based reform as commercial and Medicare Next Generation ACO programs begin.
- Increase the number of communities voluntarily participating in the program.
- Increase the number of Medicaid beneficiaries attributed to the ACO.
- Ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2018 per the requirements of the APM Agreement.

Negotiations concluded during the fourth quarter of 2017, and the final contract was signed by the Commissioner of DVHA and the CEO of OneCare on December 29, 2017.

The contract covers _____ Medicaid enrollees in 10 communities.

Commented [MMK1]: nything else? Do we want to call out VMNG support of the care model?

DVHA PRIMARY CARE PAYMENTS

In addition to changing how Medicaid pays for care, DVHA recognizes the importance of primary care in supporting the delivery system reforms needed to response to payment reforms. One way to support primary care is to create equity between Medicare and Medicaid for primary care rates. DVHA has achieved this goal by aligning payment for certain primary care codes with Medicare through its recent update to its physician fee schedule and primary care incentive payments, which became effective August 1, 2017.[2] Specifically, DVHA increased the rate paid to eligible primary care providers for certain services to equal the Medicare calendar year 2017 payment rates.[3] This increase is achieved by using a special conversion factor (CF), which was formerly called an Enhanced Primary Care Payment, or EPCP.

[2] Vermont's Global Commitment Register (GCR) provides information on Vermont Medicaid policy changes. GCR 17-061 contains information on these primary care payments. See http://dvha.vermont.gov/global-commitmentto-health/global-commitment-register.

[3] The Vermont Medical Society's comments to this proposed change listed creating equity with Medicare payments as a "major public policy milestone."

For more information on this accomplishment, review DVHA's *Vermont Medicaid Payment Alignment Report, Act 85 of 2017.*[4]

DARTMOUTH-HITCHCOCK MEDICAL CENTER SETTLEMENT

[Insert text here]

FQHC PAYMENT RECALIBRATION

[Insert text here]

DEPARTMENT OF DISABILITIES, AGING, AND INDEPENDENT LIVING REFORM INITIATIVES

DAIL was an active participant in the Medicaid Pathways project. During the process, two "cohorts" were identified, both of which included population overseen by DAIL. The first cohort included Specialized Medicaid Programs and Services within AHS Mental Health (MH), Developmental Disabilities Services (DDS), and Substance Use Disorder (SUD) Treatment Services. The second cohort included Choices for Care (CFC) and traumatic brain injury (TBI).

While the work on these cohorts specific to Medicaid Pathways has ended, DAIL continues to explore reforms to how Medicaid pays for services such that the payment rewards high quality, high value care instead of volume. The below describes these activities. As mentioned above, a cross-agency group, the Delivery System Reform Work Group, met regularly from the beginning of the year to engage in level setting around the Agency's programs and populations served. DAIL presented overviews of current LTSS (CFC, DDS, TBI) laws, rules, eligibility, provider system, services, reimbursement, quality management, outcome and performance measures. DAIL continues to participate in this group as AHS develops a workplan around aligning LTSS with financial and quality targets of the APM Agreement.

Additionally, in line with a recommendation from the previous CFC Medicaid Pathway group, DAIL convened a DAIL Advisory Board subgroup in May of 2017 to work on redesign of CFC Moderate Needs Group (MNG) payment and services. This group has met and produced draft recommendations for changes to CFC MNG eligibility and reimbursement methodology. Some preliminary recommendations from the group include:

- Expand the flexible funding option versus provider specific allocations;
- Allow provider carry forward of unspent allocation from one fiscal year to the next;
- Change eligibility standards to more accurately target intended population;
- Change wait list standards from chronological to need based.

DAIL also convened a group in the fall of 2017 to work on the redesign of DDS payment and services. The workgroup is focused on exploring a new payment ~~models~~ structures to ~~streamline procedures and~~ enhance transparency and accountability for Home and Community-Based Services for ~~adults~~individuals with developmental disabilities. ~~Furthermore~~, Tthis work is essential to establishing the foundation for informed payment reforms and will continue in 2018 with a heightened focus on accountability for service delivery, identification of costs to ensure a stable provider system and a standardized rate

[4] https://legislature.vermont.gov/assets/Legislative-Reports/Medicaid-Alignment-Report-to-Legislature-FINAL.pdf

Commented [MMK2]: etting aside since I'm not sure where this fits in anymore

1. Preserve and strengthen the successes of the Choices for Care program. Choices for Care has been nationally recognized for its innovation in LTSS. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full consumer choice in when, where, and from whom to receive services. Unlike traditional LTSS programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, home care, adult day services, and adult family care in any given eligibility period. The seamless nature of services and strong support for participant-directed care and service delivery must be preserved.
2. Foster on-going meaningful input into the reform process through continued consumer, stakeholder and provider dialogue.
3. Ensure informed consent, privacy, confidentiality, and appropriate release forms regarding information sharing, and especially among interdisciplinary team members.

structure across the state. The goal is to develop a new structure for the delivery and payment of services to individuals by the beginning of SFY 19.

Commented [MMK3]: o we have any more detail around this?

For services for children with developmental disabilities and their families, the Developmental Disabilities Services Division (DDSD) has been meeting with the Department of Mental Health (DMH) Child, Adolescent and Family Unit to explore further integration of services across the departments and at the local level. DMH and DDSD staff visited a number of Designated Agencies, who have moved forward with integrating their services for children and families. Staff identified common themes across these agencies due to integration that included following:

- Previously distinct eligibility rules restricted access and flexibility of services. Removing those opened access so more children could be served.
- Blended funding allowed a partnership between DDS/MH that created an essential culture change of working with children and families to identify the most appropriate combination of support and treatment. The changes freed up clinicians and other staff to focus on service delivery.
- Agencies no longer needed funding work-arounds for children and families to receive services.
- Agencies could tailor how services were delivered to meet unique needs of a community.
- Improving the focus on natural supports and connections to community allowed agencies to maximize efficiencies in service delivery.
- DDS and MH recognized each had skills to bring to the service delivery for a family such as clinical mental health services, family systems work, and skill development.

DDSD and DMH continue to meet to explore expanding more integrated services to more regions of the state. This work will be ongoing in 2018.

DAIL has also begun internal work to create a list of 'strengths' and 'opportunities' across DAIL LTSS, intended to inform broader reform work across CFC, DDS, and TBI.

In support of implementing the APM Agreement, OneCare invited DAIL (along with other providers and stakeholders) to participate in developing policies and procedures to implement the APM waiver of the Medicare requirement for a qualifying 3-day hospital stay before Medicare coverage of nursing facility services. Draft procedures and workflow have been developed. As of this writing, the work of this group continues.

Finally, DAIL has begun initial conversations with ~~other~~ internal stakeholders about possible changes to Medicaid rate setting and reimbursement for nursing facilities. The AHS Division of Rate Setting has direct responsibility for the current payment regulations and procedures.

DEPARTMENT OF MENTAL HEALTH REFORM INITIATIVES

The DMH is working with the DVHA Payment Reform team and in coordination with the Director of Health Care Reform to develop new payment models for reforming child and adult mental health reimbursement. The new payment structures under development are in alignment with alternative and value-based purchasing approaches. The goal is to create models that can include other AHS

departments over time, that will align with payment approaches through the APM Agreement, and that give providers the flexibility they need to implement effective service delivery approaches.

Work is currently underway in both programs, with the goal that each follow similar paths; however, the work on the children's program began earlier and has progressed farther. The target for implementing both programs of service is FY19, but that date may change to achieve the desired scope of reforms rather than reducing scope to meet a fixed timeframe.

The structure of the children's payment reform approach is depicted in the figure below. The Children's Change Workgroup oversees the process with three sub-groups focused on different components of the work (payments, quality, and operations). All workgroups are facilitated and supported by DVHA's Payment Reform team with representation from DMH (including the former Integrating Family Services Director), the Designated Agencies, and Vermont Care Partners. Depending on scope and capacity, other Departments may join the effort over time.

Figure 2. The Children's Mental Health Reimbursement Reform Organization

The DVHA payment reform team, Designated Agency representatives, and Vermont Care Partners serve as the bridge from the child mental health work groups for overlapping information and developmental milestones to inform the recently launched adult payment reform work groups.

The Children's Change Workgroup has reviewed lessons learned from the Integrating Family Services pilot regions to capitalize on effective strategies realized in these pilots and to learn from the challenges of that initiative. Work from the Medicaid Pathway has also been reviewed and incorporated into the planning where relevant, including topics such as the Vermont Model of Care, organization of the delivery system and governance expectations aligned with integrated delivery models; payment models that support value-based and population health approaches; quality and performance measurement to support value-based payments; and alternative payment models for services delivered by Designated and Specialized Service Agencies.

The Children's Change Workgroup has identified the following goals for defining a payment reform model aligned with the Triple Aim:

- Sustainable spending
  - Simplify funding streams
  - Move away from fee-for-service reimbursement
  - Increase payment predictability
  - Increase flexibility for providers
- Better Care (i.e., improved customer experience)
  - Improve access to care
  - Improve satisfaction
  - Strengthen Children's System of Care
- Healthier People (i.e., improved outcomes and value)
  - Streamline outcomes
  - Improve efficiency of quality review processes
  - Focus on improving health across a population

The Children's Payment Model & Methodology Work Group is tasked with identifying and developing an attribution methodology, the scope of services to be included, a financial methodology, and the provider payment mechanism. To date, the workgroup has identified a preliminary set of core services and funding streams to be included in the payment model. These services require more analysis and broader stakeholder input in order to be finalized, additionally, several funding streams have interagency linkages and have been identified for Commissioner review at the beginning of CY 2018. The next steps of this work group are to identify the most appropriate value-based purchasing methodology and management of risk. A key principle for the model is that it is flexible enough to adapt to needs of a community.

The Children's Operational Considerations Work Group intentionally began later than the Payment Model and Quality workgroups to allow some initial development of the payment model and measures. The group has begun to identify the current rules, policies, procedures, guidelines and manuals that relate to the proposed funding streams and services. Activities related to program integrity functions are being explored to determine what processes will be needed to support the new model and the workgroup is also considering developing internal DMH and provider agency readiness assessment tools as both DMH and the agencies will need to consider internal staffing roles and responsibility changes.

The Children's Quality & Value Component Work Group is looking at quality management and indicators, performance reporting, and information systems. See section 4 of this report for more information.

Due to its recent launch, there is no additional information about the design and development of Adult Mental Health payment and delivery reform models to be added to the report at this time.

SECTION 4: QUALITY MEASURE COLLECTION AND RESULTS-BASED ACCOUNTABILITY

DATA GOVERNANCE

Data plays a key role in supporting program operations, devising reform strategies, informing continuous quality improvement, and evaluating the efficacy of program and reform efforts. As such, AHS has committed to increasing the use of cross-agency data, improving the information technology (IT) that supports the data, and establishing a governance structure to provide essential leadership and decision making around data and health IT.

[Do we have anything on governance structure? Examples of work either internally or with external stakeholders (i.e., DAs)?]

COMPREHENSIVE QUALITY STRATEGY AND OTHER EFFORTS WITH DEPARTMENT QUALITY REPS

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During 2017, AHS continued to enhance alignment within and among the various health care reform initiatives. While the performance measures for the APM, VMNG, and Global Commitment to Health demonstration remained unchanged for 2017, performance measures associated with additional non-fee-for-service payment models were identified. Prior to CMS submission, all payment model applications were reviewed to ensure that their associated measures were representative of the array of services provided and of the diversity of individuals served as well as aligned with the broader demonstration goals and objectives. This process was informed by the Results Based Accountability methodology. Results Based Accountability helps programs improve the lives of children, families, and communities and their performance because the framework:

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- Supports moving from talk to action quickly;
- is a simple, common sense process that is easily understood;
- helps groups to identify and challenge assumptions that can block innovation;
- builds collaboration and consensus; and
- uses data and transparency to ensure accountability for both the well-being of people and the performance of programs.

The AHS uses *Clear Impact Scorecards* to strengthen continuous improvement practices, including how they measure, monitor, and improve performance. Scorecards organize, present, and share data to tell a story. According to the *Results Based Accountability* methodology, each card has two parts: population accountability and program accountability. The former is accountability by a community for the well-being of a population and involves examining results for whole populations. The latter is accountability by the managers of a program for the performance of a particular program and involves examining results for the consumers or clients served by the specific program.

In addition to promoting population accountability through statewide trends in Scorecards, AHS uses Scorecards to demonstrate the performance of Departments responsible for implementing programs, services, and various activities – many of which support the Medicaid program. For example, AHS Departments currently use scorecards to enhance regular monitoring of their Global Commitment Investments. The AHS Performance Accountability Committee is examining the feasibility of using scorecards to enhance regular monitoring and reporting of Global Commitment evaluation and payment model performance measures. Monitoring performance measures in this manner allows AHS to gauge

success or failure against a performance target or baseline and ultimately engage in a data-driven decision-making process. In addition to maintaining a cohesive dashboard of data and information across Departments, this approach is also consistent with AHS's commitment to enhancing understanding and use of RBA within a broader system of accountability for all programs and services toward improved quality of service and outcomes.

APM AND DVHA – QUALITY, MEASURES, AND ACCOUNTABILITY

The APM Agreement included three broad population health measures: increasing access to primary care, reducing the growth in prevalence of chronic conditions (diabetes, hypertension, and chronic obstructive pulmonary disease), and reduce the number of deaths due to suicide and substance use disorder. More information on the specifics of those measures can be found in Appendix 1 of the APM Agreement. [cite] The GMCB, in collaboration with AHS, is responsible for monitoring the progress OneCare and the state are making towards achieving health outcomes and quality of care.

In the VMNG 2018 contracts, Attachment B, Section J lists the quality and outcome measures for which the OneCare is responsible. It also describes the Quality Incentive Pool Program, which aims to incentivize OneCare to ensure high quality care and good health outcomes under an all-inclusive population-based payment. [cite]

DAIL – QUALITY, MEASURES, AND ACCOUNTABILITY

Successfully shifting from fee-for-service to flexible payment models involves a key role of quality and performance measures to monitor whether appropriate care has been delivered. As DAIL and their community partners move toward reforming payment for LTSS in alignment with the ACO and under the APM Agreement, LTSS performance and quality measures need to be addressed. These measures provide the accountability to ensure that LTSS payments are linked with high quality, high value care. However, neither the APM Agreement nor the Vermont Medicaid Next Generation ACO model contract between DVHA and OneCare include LTSS measures that address the purpose and scope of LTSS. Therefore, as AHS works with the ACO and the GMCB to develop a plan for incorporating home- and community-based services and institutional services into the financial and quality targets of the APM Agreement, development of appropriate measures for these services is key.

The development of quality and performance measures for LTSS is ongoing, informed by both national developments and continued work under Global Commitment in Vermont. In 2016 and 2017, the NQF has made important progress on relevant measures. More information on this work can be found at:

- http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx
- https://www.qualityforum.org/Publications/2017/09/Medicaid_Innovation_Accelerator_Project_Final_Report.aspx

Additionally, 2017 saw the release of a CAHPS HCBS consumer survey module by CMS:

- https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

Based on this body of work, DAIL has begun compiling protential measures. These include but are not limited to:

Performance category	Performance Measure	Population	Source of Data	Frequency of Measurement
Eliminating Institutional Bias	Average number of people served per month by setting: nursing facility, home, licensed residential facility	CFC population	MMIS	Annual
Community Access	Proportion of people who do things they enjoy outside of their home when and with whom they want to	CFC, TBI, DDS Representative Samples	NCI-AD	Annual
Choice and Control	The proportion of people who make choices about their everyday lives (composite score regarding choice of daily schedule, how to spend money and free time activities)	DDS Representative Sample	NCI-DD	Annual
Choice and Control	Proportion of people who can choose or change what kind of services they get and determine how often and when they get them	TBI Representative Sample	NCI-AD	Annual
Employment	Proportion of people who have a paying job in the community, either full-time or part-time	CFC and TBI Representative Samples	NCI-AD	Annual
Employment	Proportion of people who would like a job (if not currently employed)	CFC, TBI, DDS Representative Samples	NCI-AD	Annual
Employment	Employment rate of people of working age receiving developmental disabilities services	DDS population of working age	State method	Annual
Employment	Employment rate of people of working age receiving TBI rehabilitation services	TBI population receiving rehabilitation	State method	Annual
Health Wellness	The proportion of people who describe their overall health as poor	CFC, TBI, DDS Representative Sample	NCI-AD	Annual

Other sources in Vermont to consider for relevant measures include:

- DA/SSA Master Grant performance measures
- DLP HHA survey results and CMS star ratings
- DLP NF survey results and star ratings
- Other NCI consumer survey results for CFC, DDS and TBI
- Critical incident reports

DMH – QUALITY, MEASURES, AND ACCOUNTABILITY

The children's mental health payment reform Quality and Value Component Workgroup is exploring what indicators will be used to evaluate program success and how providers will report on their performance. The group identified the following key qualities for selection of measures. The measures should-

- include population level outcomes
- increase the quality and value of the programs and services provided
- be feasible to collect
- provide meaningful data for continuous quality improvement efforts

The workgroup conducted a measurement inventory to identify measures from multiple sources, including Integrating Family Services, Centers for Excellence, and DMH master grant reporting requirements. Each measure was evaluated using the Medicaid Pathway Measure Selection Criteria[5] created in 2016. Measures were sorted into three categories based on how well they meet the criteria and how they fit with the APM Agreement and Results Based Accountability frameworks. Some measures have been eliminated from the list and those remaining continue to be refined to ensure that there is adequate variety in the measures to meet the principles identified for the model.

Next steps include identifying which of the selected measures to propose for value-based payments. Once the workgroup has finalized the recommended list of measures and proposed value-based payment measures, feedback will be solicited from the overarching Children's Change Workgroup and leadership. The finalized measures will be incorporated into the payment model.

Many of the performance measures and outcomes being considered for payment reform and the comprehensive quality strategy are reflected within DMH's Results Based Accountability scorecards. As payment reform progresses through the Quality/Value Component Work Group, the indicators and performance measures will change to align with these efforts.

In addition, over the past year, DMH has put considerable effort into creating a system of accountability for the Designated Agency Master Grant agreements. The Department has created a system to monitor performance measure submission and evaluation by Departmental program directors. Designated Agencies are expected to a unified set of performance measures for each program, as well as one performance measure that reflects what each mental health program at each Designated Agency uses to evaluate its own performance. The intent is to create a system that reinforces results based accountability from the top-down through state agency selected performance measures and outcomes and from the bottom-up through program selection of performance measures. The Department is also piloting the potential of using the RBA Clear Impact scorecard software as a tool for Designated Agencies to use to submit performance measure information to the Department, which will eliminate some administrative effort and delays in reporting between the Agency and the Department.

[5] The criteria were outlined *Medicaid Pathway Overview* report (p. 19): http://dvha.vermont.gov/global-commitment-to-health/medicaid-pathway-planning-overview-12.19.16-update.pdf

Finally, as part of the Agency of Human Services, the DMH uses the Results Based Accountability framework to evaluate the performance of our programs and initiatives.

Using several scorecards, DMH presents data and performance measures related to the department's programs and system of care. These outcomes include ensuring that all Vermonters are healthy. DMH also collaborates with many partners to reduce the suicide rate in Vermont and increase the availability of mental health treatment (both indicators).

The Department of Mental Health (DMH) Scorecard

- high level presentation of the Department's Programs and areas of focus
  https://app.resultsscorecard.com/Scorecard/Embed/9939

Reducing Seclusion and Restraint in Vermont's Psychiatric Hospitals

- data presented to the Emergency Involuntary Procedures (EIP) Workgroup and used by the Department to evaluate our initiative to reduce seclusion and restraint on inpatient psychiatric units
  http://app.resultsscorecard.com/Scorecard/Embed/10396

Vermont Psychiatric Care Hospital (VPCH) Outcomes

- Scorecard generated in response to legislative requirement to identify "desired outcomes, performance measures, and data requirements required to measure whether the hospital is achieving the stated outcomes for patient care, and the effectiveness of treatment services, patient monitoring, and safety requirements at the Vermont Psychiatric Care Hospital"
  http://app.clearimpact.com/Scorecard/Embed/8136

DMH System Snapshot

- Scorecard generated in response to 2012 Act 79, an act reforming the mental health system of care that details system measures on a quarterly basis
- http://app.resultsscorecard.com/Scorecard/Embed/14725

DMH Continued Reporting

- Scorecard generated in response to request for on-going quarterly measures that are presented in the annual Act 79 Report to the legislature
- http://app.resultsscorecard.com/Scorecard/Embed/14723

SECTION 5: CONCLUSION

The focus for 2017 was to stand up the VMNG ACO Pilot Program. It was also a year in which AHS worked closely with OneCare to prepare for 2018 and the expansion to Medicare and BCBSVT and the expansion in the number of hospitals, providers, and Vermonters participating in payment and delivery system reforms under the APM Agreement. It was also a year in which AHS looked closely at the work under its purview to evaluate equity in payments, accountability for the services rendered, and data the data and IT available. In some areas, the Agency was able to take significant steps forward, such as

increasing primary care reimbursement rates and establishing a clear decision-making process around IT. In other areas, work continues to evolve. Understanding where the gaps are in accountability is the first step before accountability can be improved and serve as keystone to payment reform. DVHA, DAIL, and DMH continue to make progress in this area.

As we look ahead to 2019 with the state's responsibilities under the APM Agreement in mind, the state will have to work closely with OneCare, the DAs, SSAs, and other community providers to build on 2017's progress and to identify services and providers that are prepared to undertake the changes necessary for successful payment and delivery reform.

APPENDICES

Timeline of required APM deliverables

Jenney Samuelson

Timeline of required APM deliverables

Commented [SJ7]: If you want more detail, I would recommend putting in the full table from the GMCB/AHS MOU

January 1, 2017

- Implement the **Medicaid Next Generation ACO** Program

June 30, 2020

- Develop a plan that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to **Community Health Services** is being used toward achieving the Statewide Health and Quality of Care Targets

December 31, 2020

- Develop a plan to coordinate the financing and delivery of Medicaid **Behavioral Health Services** with the All-Payer Model financial targets
- Develop a plan to coordinate the financing and delivery of Medicaid **Home and Community Based Services** with the All-Payer Model financial targets (December 31, 2020)

January 1, 2021 to December 30, 2022

- Add Medicaid Long-Term Institutional Services in All-payer Financial Target Services for Performance Year

Other? Final pre-print submissions for all non-FFS payment models to CMCS?

Kennedy, Alice

From: Hutt, Monica
Sent: Wednesday, January 10, 2018 12:29 PM
To: Julie Tessler ; Elizabeth Sightler; Moultonl, Mary
Subject: Rep letter to CMS re HCBS rules
Attachments: Faso_Congregate_Settings_Letter_to_CMS_11272017_3.pdf

Here is that letter to CMS that I referenced today. Monica

Monica Caserta Hutt, Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
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19TH DISTRICT, NEW YORK

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SUBCOMMITTEE ON ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT

SUBCOMMITTEE ON HIGHWAYS AND TRANSIT

Congress of the United States
House of Representatives

November 27, 2017

Honorable Seema Verma
Administrator
U.S. Centers for Medicare and Medicaid Services
200 Independence Avenue, Southwest
Washington, DC 20201

Dear Administrator Verma,

We are writing today in support of immediate changes to CMS' March 2014 "Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community." We are encouraged to hear that CMS is currently in the process of revising this guidance, and we hope that you will be able to provide us with a positive update in the very near term. We write today both to express our desire to see this guidance document changed, and to share our views on the value and importance of disability-specific congregate, farmstead, and lifesharing communities in the Medicaid program. As written, the guidance discriminates against these communities, as well as against other rural-based settings which offer individuals with disabilities an important choice as they consider the setting that best meets their individualized needs.

As you are aware, in January 2014 CMS issued a final rule on Home and Community-Based Services (HCBS) waivers. The intent of the rule was broadly supported, enshrining into regulation the importance of patient choice and dignity. Following publication of the final rule, in a March 2014 guidance document CMS took the position that disability-specific congregate and farmstead communities are more likely than other community-based settings to "isolate" individuals from the broader community and are therefore subject to a "heightened scrutiny" standard before CMS considers them to meet the home and community-based services standards. While we support protections which ensure that individuals receiving HCBS have full access to the benefits of community living, we believe the guidance document, as written, reflects a fundamental misunderstanding of how many disability-specific congregate, farmstead, and lifesharing communities operate.

We are particularly concerned that the guidance may have the unintended impact of discouraging and ultimately phasing out congregate and lifesharing models which promote individual independence, community integration, and enhanced quality of life for all served by these communities. These models, many of which are located in congregate and farmstead settings, are an important choice for Medicaid beneficiaries as they search for the particular setting that

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PHONE: (845) 514-2322

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best fits their own individualized needs. In subjecting these communities to a heightened scrutiny standard, CMS has introduced significant uncertainty to the future of these communities.

By painting all congregate and farmstead communities with a broad brush, CMS threatens to remove a critical choice from individuals looking for a setting that provides individuals with a community that supports inclusion, not seclusion. We applaud CMS' intent in the 2014 final rule to protect patient choice and dignity, but urge CMS to revise its subsequent guidance to clarify that congregate and farmstead communities based on the lifesharing model are not subject to the heightened scrutiny standard. We understand that these communities would welcome third party certification (such as through the Center for Quality and Leadership) as an alternative to the current broad-brush policy.

Thank you for your time and consideration,

Sincerely,

John J. Faso
Member of Congress

Jacky Rosen
Member of Congress

Raja Krishnamoorthi
Member of Congress

cc: Brian Neale, Director, Center for Medicaid and CHIP Services
Tim Hill, Deputy Director, Center for Medicaid and CHIP Services
Michael Nardone, Director, Disabled and Elderly Health Programs Group
Ralph Lollar, Director, Division of Long Term Services and Supports
Melissa Harris, Senior Policy Advisor, Disabled and Elderly Health Programs Group

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Ralph Lollar, Director, Division of Long Term Services and Supports
Melissa Harris, Senior Policy Advisor, Disabled and Elderly Health Programs Group

Kennedy, Alice

From: Hutt, Monica
Sent: Thursday, January 18, 2018 9:08 AM
To: McFadden, Clare; Hill, Bard
Subject: RE: 1/22 112:30: Prep for Heartbeet meeting on January 23rd

Excellent, thanks!

Monica Caserta Hutt, Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
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E-mail: monica.hutt@vermont.gov
http://www.dail.vermont.gov/

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From: McFadden, Clare
Sent: Wednesday, January 17, 2018 2:39 PM
To: Hutt, Monica ; Hill, Bard
Subject: RE: 1/22 112:30: Prep for Heartbeet meeting on January 23rd

No, I have been there and do not need to attend this time. Just so you know where things are at. Heartbeet is very concerned about whether they can continue to receive funding under the HCBS rules as a called out setting that on the face of it could be seen as institutional in nature. They went ahead and had themselves reviewed by CQL who certified them. I have explained to Hannah that that is all well and good, but CQL certification does not equate to meeting the HCBS setting rules. I said that we would be happy to review their report from CQL, but that we will be doing a site visit to determine if they are in compliance or not and if we as a state will support them under the "heightened scrutiny" process as an organization that meets the requirements despite being a congregate setting. Chris and the QM team have a plan regarding site visits to validate the initial survey information that was gathered. Heartbeet is very eager to get our blessing and they are quite politically saavy and are working the crowd to drum up support. I know they are eager to get this settled, but we will get the them in due course. I would not prejudge whether they meet the requirements or not at this point. Best to stay neutral at this time. Thanks.

From: Hutt, Monica
Sent: Wednesday, January 17, 2018 2:21 PM
To: Hill, Bard <Bard.Hill@vermont.gov>; McFadden, Clare <Clare.McFadden@vermont.gov>
Subject: Re: 1/22 112:30: Prep for Heartbeet meeting on January 23rd

It's just Mary Kate and I visiting - clare you are more than welcome to attend

Get Outlook for iOS

From: Hill, Bard
Sent: Wednesday, January 17, 2018 1:45:32 PM
To: McFadden, Clare; Hutt, Monica
Subject: FW: 1/22 112:30: Prep for Heartbeet meeting on January 23rd

It looks like DDSD reps were not invited...
Bard

-----Original Appointment-----
From: Hill, Bard
Sent: Wednesday, January 17, 2018 1:44 PM
To: Mohlman, Mary Kate
Subject: Accepted: Prep for Heartbeet meeting on January 23rd
When: Monday, January 22, 2018 12:30 PM-1:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Monica's office

Kennedy, Alice

From: Hutt, Monica
Sent: Monday, January 30, 2017 9:06 AM
To: Beth Stern; Forkas, Colleen; Tierney-Ward, Megan
Subject: RE: Case Management Standards

Beth, We essentially received confirmation from CMS, acknowledging this as an issue for Vermont but not the direction from them that we had requested. We, through the Secretary's office, did reach out again asking for that direction and they indicated that they would provide it but they are in the midst of a communication ban right now. So nothing new to report at this time. Thanks, Monica

Monica Caserta Hutt, Commissioner
Vermont Department of Disabilities, Aging and Independent Living
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"If the spirit of liberty should vanish in other parts of the Union, and support of our institutions should languish, it could all be replenished from the generous store held by the people of this brave little state of Vermont." Calvin Coolidge

---

From: Beth Stern [mailto:bstern@cvcoa.org]
Sent: Friday, January 27, 2017 3:06 PM
To: Forkas, Colleen ; Tierney-Ward, Megan ; Hutt, Monica
Subject: RE: Case Management Standards

Hi Monica, Colleen and Megan,

Thank you for this. I am wondering if you ever received any response to your letter to CMS from last August regarding Conflict of Interest in Case Management? If so, could you share it with me? Is DAIL still in discussion with CMS regarding this issue?

Thanks!

Beth

From: Forkas, Colleen [mailto:Colleen.Forkas@vermont.gov]
Sent: Tuesday, January 17, 2017 3:28 PM
To: Beth Stern; Carol Stamatakis; J Michael Hall; Janet Hunt; Meg Burmeister; Sandy Conrad (sconrad@svcoa.net); Bean, Marie; George, Camille; Rainville, Kathy; Sara Lane; Tierney-Ward, Megan; B Cody; Barbara Keough; Danell Huntley; Janet McCarthey; Jeanne McLaughlin; Jill Olson; Judy Peterson; Kathy Demars; Lyne Limoges; Nick McCardle; Ron Cioffi; Sandy Rousse; Shawn Tester; Sherry Greifzu; Treny Burgess (trenyb@nchcvt.org)
Subject: FW: Case Management Standards

Sending on behalf of Megan Tierney-Ward

Colleen Forkas
Administrative Services Coordinator III
DAIL/Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-2070
Colleen.forkas@vermont.gov
Phone: 802-241-0294 Mon. Tues. Wed.
Cell: 802-760-8372 Thurs. Fri

Our new central office main phone number is (802) 241-0294 and the fax is (802) 241-0385

"To succeed in life, you need three things. A wishbone, a backbone and a funny bone."

Good afternoon,

As you know, DAIL has updated the Case Management Certification Standards to reflect the new HCBS regulations. The link below will bring you the current standards in place January 2017. I've also included a link to the HCBS Regulations section of our website for your information. Please continue to consult with Stuart Senghas regarding the standards as they relate to your agency's certification.

New Case Management Standards:
http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf
HCBS Regulations Information: http://asd.vermont.gov/special-projects/federal-hcbs

Thank you,

Megan Tierney-Ward
Adult Services Division Director

NEW ASD Website: http://asd.vermont.gov/

Department of Disabilities, Aging & Independent Living
Adult Services Division

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Waterbury, VT 05671-0270

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Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Forkas at colleen.forkas@vermont.gov. Thank you.

NEED ASSISTANCE?

Contact your local Aging & Disabilities Resource Connection partner:

- Vermont 211: Dial 211
- Senior Helpline: 1-800-642-5119 (for people 60 and older)
- VT Center for Independent Living: 1-800-639-1522 (for people under 60)
- Brain Injury Association of VT: 1-877-856-1772

DISCLAIMER: This email may contain confidential information. If you think you have received this message in error, please notify the sender, delete the message, and refrain from distributing it further. We do not guarantee that this material is free from viruses or any other defects, although due care has been taken to minimize the risk. Thank you.

Kennedy, Alice

From:	George, Camille
Sent:	Tuesday, June 19, 2018 2:00 PM
To:	Hutt, Monica
Subject:	FW: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission
Attachments:	RE: Follow up question on CFC HHA/AAAs; RE: Vermont Choices for Care Program Summary and Proposed Planning to Strengthen Conflict of Interest Protections; Conflic Free Case Management_DA_DMH(03).docx

See highlighted below, could be a problem. I will speak with Clarence before sending anything out and also about the issue highlighted below. I was clear in a message to him that one question is what information is public and how to share it.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
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Cell Phone: 802.798-2079
E-mail: camille.george@vermont.gov
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June is Alzheimer's and Brain Awareness Month! Over 13,000 Vermonters are living with Alzheimer's Disease, but growing evidence indicates that people can reduce their risk of cognitive decline by adopting key lifestyle habits. Learn the 10 Ways to Love Your Brain. If you are concerned about a loved one or yourself, ask your health care provider to perform a brief cognitive assessment. Early screening gives more time for families to plan next steps and access helpful resources and supports. Cognitive screening is included in Medicare's annual Wellness Visit and Medicare also offers a new benefit for dementia planning support. For questions, local resources and support, contact the Alzheimer's Association Vermont Chapter at 1-800-272-3900.

From: Hickman, Selina
Sent: Tuesday, June 19, 2018 1:34 PM

To: George, Camille ; Skaflestad, Shawn ; Davis, Clarence
Subject: RE: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission

Hi Camille,

You have the major communications sent to CMS. I've attached two emails and another document that could be helpful:

- Re: Vermont Choices for Care Program Summary and Proposed Panning to Strengthen Conflict of Interest Protections: this email shows multiple attempts to gain response from CMS on the CFC conflict of interest exception request. It also highlights what we and they understand; the exception criteria is not a perfect fit for Vermont's situation, as there is more than one available case management agency.
- Re: Follow up question on CFC HHA/AAAs: this email shows CMS confirmation that our follow up response was received.
- Conflict Free Case Management_DA_DMH(03): this document was sent to CMS on 9/22/17 and seeks the conflict free case management exception for mental health programs and services provided through Designated Agencies. This brief is able to show clearly that there is only one willing and qualified case manager for Mental Health HCBS services. No response has been received to this brief.

Finally, CMS indicated to the State of Vermont in conversations that any exception to the conflict free case management requirements described in federal regulations must be enacted through an amendment to our 1115 waiver. At the time, we decided the next opportunity to ask for the exception would be through the SUD amendment process, however, I do not believe that loose end was tied off prior to the SUD amendment approval.

Let me know if there is anything else I can assist with.

VERMONT | Selina Hickman
Director of Policy
Department of Mental Health

From: George, Camille
Sent: Tuesday, June 19, 2018 11:49 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Davis, Clarence <Clarence.Davis@vermont.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: FW: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission

Thanks for sending this information along, Shawn. Clarence, I'd like to touch base with you about this. At last week's DAIL Advisory Board meeting, Shawn and a couple DAIL staff provided an update on the progress being made in implementing the CMS Home- and Community-Based Services Rules. In the course of the update, the topic of conflict-free case management came up and some present requested to receive a copy of the conflict free case management waiver exemption that the state filed with CMS and related documentation. This is a pretty sensitive topic, with strong opinions on both sides. Before we send anything out to the DAIL Advisory Board (and in fact, it was 2 staff from the DD Council who are not members of the DAIL Advisory Board, but were in attendance) I'd like to consult and make sure we are on the same page about what we send out. I've cc'd Selina as I know she was very involved in this process and the exemption request and may both be aware of additional documentation and have some helpful advice.

Do you have time to touch base about this within the next week or so?

Also, Shawn, if you can send me the link to the DVHA webpage that contains the additional information about the Comprehensive Quality Strategy and other information related to the HCBS rules, I can include that once we sort out what additional information will be shared.

Thanks.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
Cell Phone: 802.798-2079
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/

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From: Skaflestad, Shawn
Sent: Tuesday, June 19, 2018 10:47 AM
To: George, Camille <Camille.George@vermont.gov>
Cc: Davis, Clarence <Clarence.Davis@vermont.gov>
Subject: FW: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission

Hi Camille – as per your request after last week's DAIL Advisory Board Meeting – attached are the following conflict-free case management items:

- Geographic exception request application (pdf: CFC Brief Action Plan – pp. 5 and 6)
- CMS correspondences (Outlook item: Follow Up question on CFC + embedded pdf: Vermont response)

I have copied Clarence because this item as discussed with him and Martha back in April – and I am not sure if any action has been taken since that meeting. Please let me know if you have any questions re: the attached documents.

Best,

Shawn

Kennedy, Alice

From: Hickman, Selina
Sent: Friday, June 23, 2017 11:36 AM
To: Schenck, Tom M.(CMS/CMCHO); Skaflestad, Shawn
Cc: Hutt, Monica
Subject: RE: Follow up question on CFC HHA/AAAs

Great- thank you, Tom!

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
(802) 585-9934

From: Schenck, Tom M.(CMS/CMCHO) [mailto:Tom.Schenck@cms.hhs.gov]
Sent: Friday, June 23, 2017 11:34 AM
To: Hickman, Selina <Selina.Hickman@vermont.gov>; Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Thanks, Selina! Glad to have you back! I've passed this along to our HCBS SMEs and I'll be in touch once I know next steps.

From: Hickman, Selina [mailto:Selina.Hickman@vermont.gov]
Sent: Friday, June 23, 2017 10:58 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Schenck, Tom M.(CMS/CMCHO) <Tom.Schenck@cms.hhs.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Hi Tom,
I am back from leave and following up on your below inquiry from 5/4. Please see attached for Vermont's response and let me know if there is additional follow up needed.
I hope you are well!

Best,

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
(802) 585-9934

From: Skaflestad, Shawn
Sent: Friday, May 05, 2017 10:48 AM
To: Schenck, Tom M.(CMS/CMCHO) <Tom.Schenck@cms.hhs.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Tom – thanks for the follow up question. I will confer with the appropriate folks here at the agency and be back in touch.

Best,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
Agency of Human Services
280 State Drive Center Building
3rd Floor – E310-1
Waterbury, VT 05671-1000
Office: (802) 241-0961
Cell Phone: (802) 585-4410
Fax: 802-241-0450

Find out how Vermonters are doing with the AHS Results Scorecard.
(Access through Internet Explorer 10, Firefox, or Google Chrome).

From: Schenck, Tom M.(CMS/CMCHO) [mailto:Tom.Schenck@cms.hhs.gov]
Sent: Thursday, May 04, 2017 5:32 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: Follow up question on CFC HHA/AAAs

Hi Shawn,

I'm following up on this memo from last summer regarding the geographically designated HHAs that CMS is reviewing. We're wondering about item 1a on page 6. Could you elaborate on the statement regarding a potential determination that the HHAs/AAAs are the only qualified entities to provide both direct care and case management services. Specifically, does VT believe that to be the case statewide or only in certain geographic entities? Any further information that could help us consider a potential designation would be helpful.

Thanks,

Tom Schenck
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
(617) 565-1325

Kennedy, Alice

From: George, Camille
Sent: Friday, June 29, 2018 9:43 AM
To: Hutt, Monica; Hill, Bard; McFadden, Clare; Tierney-Ward, Megan; Courcelle, Andre
Subject: update: conflict free case management and clarification about roles between AHS and DVHA

Hi Everyone (and please share with any other staff who need this information):

A lot has happened around the topic of conflict-free case management in the past few weeks and I am writing to update you:

- The topic was raised at the June 14 DAIL Advisory Board meeting as Shawn Skaflestad, Clare and Andre were providing an update on implementation of the CMS HCBS rules. Also in attendance at the meeting were 2 staff from the DD Council that raised the issue, but then members of the DAB were also very interested. At that time, the DAB requested copies of the CM waiver exemption request that was submitted to CMS and any related communication to/from CMS.
- I followed up with AHS Interim Deputy Secretary Clarence Davis with a cc to Selina Hickman. Selina provided some documentation and also included a number of additional AHS staff (including DMH, DVHA, etc). In her communication, Selina raised that CMS had already advised that the way to go about doing this would be to request an amendment to the 1115 waiver and that the plan was to include it with the recently authorized Substance Use Disorder waiver amendment, but that the amendment request re: conflict free case management was not included in that amendment (I later learned at the meeting discussed below that CMS discouraged VT from including it, stating that the topic is very controversial and could slow down the approval of the SUD waiver). It was agreed that we would meet to brief Clarence and come up with a plan.
- In the meantime, the DD Council filed 2 very broad public records requests, 1 with DAIL and 1 with AHS.
- The DD's Council was subsequently withdrawn, as state employees cannot file FOIA requests, but DAIL indicated to DD Council staff Susan Aranoff that I was already working on the request from the DAIL Advisory Board and would share the information with her.
- At the meeting, we briefed Clarence about the rule and the history, background and VT specific complexities related to the conflict-free case management rule. This is when I got additional clarity about the message from CMS that a waiver amendment would need to be submitted and approved.
- We also agreed that Ashley Berliner would do some research about the rule, where things stand, where we have gaps, identify liabilities/risks related to compliance, etc. and then we would come back together to discuss options and come up with a plan moving forward.
- I've made a note to check in with Ashley about conflict free CM in a couple weeks if we have not heard from her by then.

We also had an opportunity to clarify/discuss communication/roles and who needs to be brought into what conversations:

Ena Backus supervises Shawn S (and others, but I didn't get their names) and their group focuses on quality and compliance. Ashley is head of Medicaid Policy. However, since policy, quality and compliance are all

intertwined, it was advised that when we have issues that arise related to Medicaid (not just re: the conflict free CM or HCBS rules), that we reach out to both Ena and Ashley and they can determine if and who needs to be involved.

I hope this update is helpful. Please let me know if you have any questions.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
Cell Phone: 802.798-2079
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/

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Kennedy, Alice

From: Leigh Holliday <leigh@heartbeet.org>
Sent: Tuesday, July 10, 2018 2:48 PM
To: Perreault, Liz
Cc: Schwartz, Hannah; McFadden, Clare; Hutt, Monica
Subject: Re: Heartbeet

Hello Liz,

Let's plan for 7/26 at 11:15a, Hannah and I will be in the same place, and can use our conference phone. Thank you very much for coordinating!

Best,
Leigh

Leigh Holliday
Licensing and Compliance
Heartbeet Lifesharing, Inc.
218 Town Farm Road
Hardwick, VT 05843
www.heartbeet.org

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On Tue, Jul 10, 2018 at 10:45 AM, Perreault, Liz <Liz.Perreault@vermont.gov> wrote:

Hi Leigh and Hannah,

Here are some dates and times that work for Clare and Monica for the phone conversation. Please let me know what works for you and I will send the meeting request out. Also, please let me know if you two will be in the same room and can use a speaker phone or that you will be in separate locations.

7/26 11:15-12:00

8/7 9:00-9:45

8/21 11:15-12:00

Thanks!

Liz

From: Leigh Holliday <leigh@heartbeet.org>
Sent: Tuesday, July 03, 2018 11:30 AM

To: Hutt, Monica <Monica.Hutt@vermont.gov>
Cc: Perreault, Liz <Liz.Perreault@vermont.gov>; Hannah Schwartz <Hannah@heartbeet.org>
Subject: Re: Heartbeet

Hello Monica,

That sounds good, we had a conversation today with Clare and wanted to stay synced with you. We will work with Liz to set up a time, and we appreciate your openness. Liz, can you send along a few dates and times that work for this call?

Thank you again, we look forward to the conversation.

Hannah and Leigh

Leigh Holliday

Licensing and Compliance

Heartbeet Lifesharing, Inc.

218 Town Farm Road

Hardwick, VT 05843

www.heartbeet.org

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On Tue, Jul 3, 2018 at 11:24 AM, Hutt, Monica <Monica.Hutt@vermont.gov> wrote:

> Leigh, you can work through Liz Perreault to schedule a time for a conversation. It might make sense to include Clare in that so that we stay synced up. Thanks! Monica
>
> **Monica Caserta Hutt, Commissioner**
>
> **Vermont Department of Disabilities, Aging and Independent Living**
>
> **Commissioner's Office**
>
> **HC 2 South**
>
> **280 State Drive**

Waterbury, VT 05671-2020

Telephone: 802.241.2401

E-mail: monica.hutt@vermont.gov

http://www.dail.vermont.gov/

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From: Leigh Holliday <leigh@heartbeet.org>
Sent: Tuesday, July 03, 2018 11:04 AM
To: Hutt, Monica <Monica.Hutt@vermont.gov>
Cc: Hannah Schwartz <Hannah@heartbeet.org>
Subject: Heartbeet

Hello Monica,

After a conversation with Clare regarding the review process that Heartbeet will be undergoing as part of Vermont's response to the CMS Final Rule on HCBS we would like to schedule a time to speak with you.

Can you send some dates/times that work for you? We appreciate your time and availability.

Best,

Hannah and Leigh

Leigh Holliday

Licensing and Compliance

Heartbeet Lifesharing, Inc.

218 Town Farm Road

Hardwick, VT 05843

www.heartbeet.org

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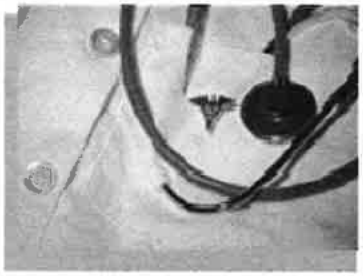
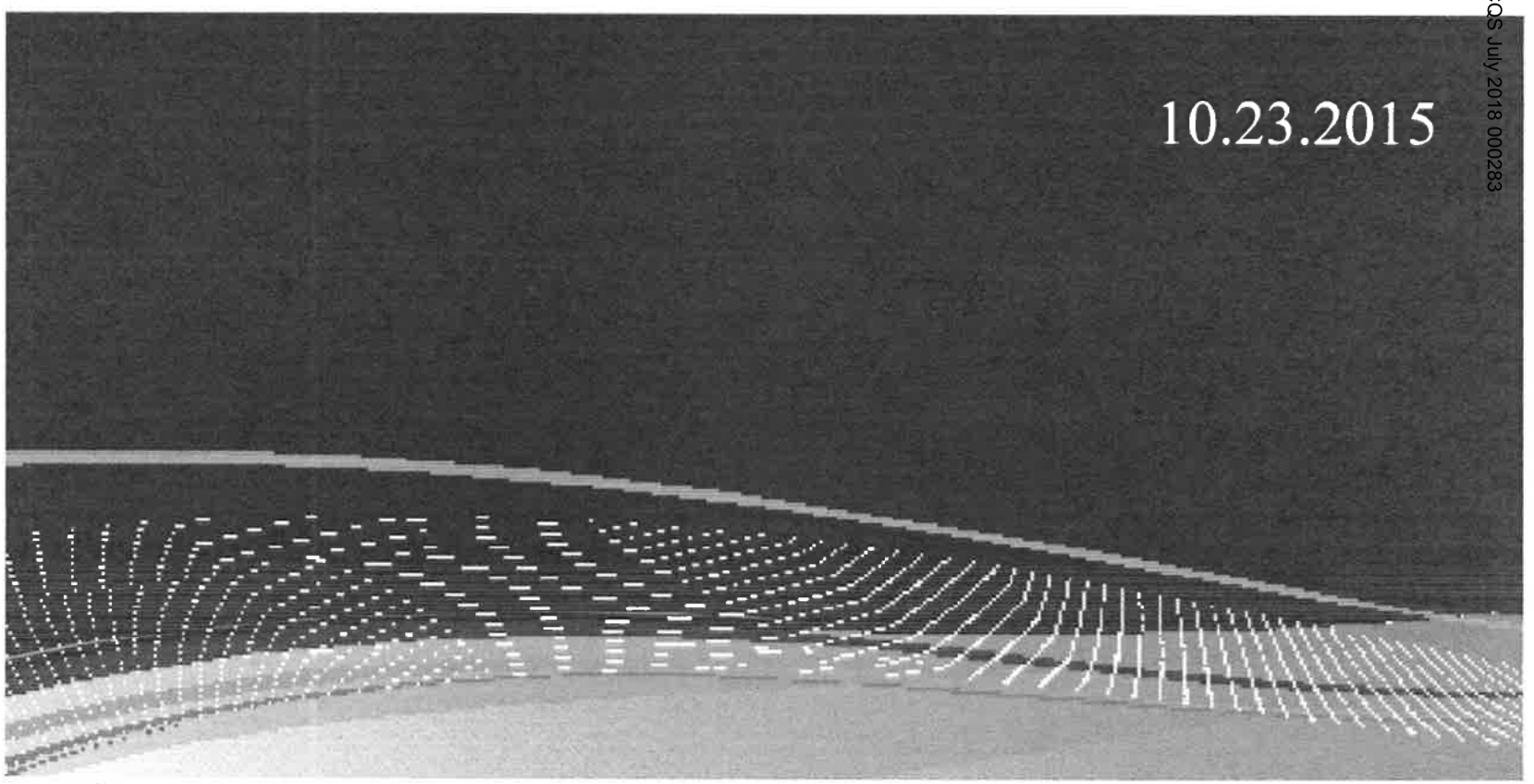
Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process





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HCBS CQS July 2018 000283

Overview

- Background – Home and Community-Based Setting Requirements
- Excluded Settings
- Settings Presumed to Have the Qualities of an Institution
  - Settings with the Effect of Isolating Individuals
- Heightened Scrutiny Process
- Questions

HCBS CQS July 2018 000284

Background – Final Rule

- The final home and community-based services (HCBS) regulations (known as the "Final Rule") were published in the Federal Register on January 16, 2014; they became effective March 17, 2014
- Designed to enhance the quality of HCBS, provide additional protections, and ensure full access to the benefits of community living

HCBS CQS July 2018 000285

Background – Home and Community-Based Setting Requirements in Final Rule

- Establishes requirements for the qualities of settings where individuals live and/or receive Medicaid-reimbursable HCBS provided under sections 1915(c), 1915(i), 1915(k), 1915(b)(3), and 1115 of the Social Security Act
- Focus on the quality of individuals' experiences
- The intent is that individuals receiving Medicaid-funded HCBS have the opportunity to receive these services in a manner that protects individual choice and promotes community integration

HCBS CQS July 2018 000286

Background – Home and Community-Based Setting Qualities

Any residential or non-residential setting where individuals live and/or receive HCBS must have the following five qualities:

1) Is integrated in and supports full access of individuals to the greater community
   - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and
   - Ensures that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS

HCBS CQS July 2018 000287

Background – Home and Community-Based Setting Qualities (cont'd)

2) Is selected by the individual from among setting options including non-disability specific settings and options for a private unit in a residential setting
   - Person-centered service plans document the options based on the individual's needs, preferences, and for residential settings, resources available for room and board

HCBS CQS July 2018 000288

Background – Home and Community-Based Setting Qualities (cont'd)

3) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint

4) Optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact

5) Facilitates individual choice regarding services and supports, and who provides them

HCBS CQS July 2018 000289

Background – Home and Community-Based Setting Qualities (cont'd)

- A residential setting that is provider-owned or controlled is subject to additional requirements
  - A setting is provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS
  - Additional requirements relate to ensuring tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home

HCBS CQS July 2018 000290

Background – Home and Community-Based Setting Requirements

- States must submit a Statewide Transition Plan for existing 1915(c) and 1915(i) programs
  - Describes the state's process for ensuring compliance with home and community-based setting requirements
- New 1915(c) waivers or new 1915(i) or 1915(k) state plan amendments must be compliant as of the effective date of the waiver or state plan amendment approved by CMS
- States must be in full compliance no later than March 17, 2019

HCBS CQS July 2018 000291

Home and Community-Based Settings – Private home

- A state may presume that an individual's private home or a relative's home where an individual resides meets the home and community-based settings requirements
- However, it is still the state's responsibility to ensure that individuals living in a private home or a relative's home have opportunities for full access to the greater community

HCBS CQS July 2018 000292

Home and Community-Based Settings – Private home (cont'd)

- If the state is operating under a presumption that a private home is meeting the setting requirements, the state needs to confirm that the setting was not purchased or established in a manner that isolates the individual from the community of individuals not receiving Medicaid-funded home and community-based services

HCBS CQS July 2018 000293

Excluded Settings

Settings that are not home and community-based are specified in the Final Rule:

- Nursing Facility
- Institution for Mental Disease
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Hospital
- Other locations that have qualities of an institutional setting, as determined by the Secretary

HCBS CQS July 2018 000294

Settings Presumed to Have the Qualities of an Institution

- The regulations identify other settings that are presumed to have institutional qualities and do not meet the requirements for Medicaid home and community-based settings:
  - Settings in a publicly or privately operated facility that provides inpatient institutional treatment
  - Settings in a building on the grounds of, or adjacent to, a public institution
  - Settings with the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

HCBS CQS July 2018 000295

Settings with the Effect of Isolating Individuals

- CMS' *Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community* states that the following two characteristics alone might, but will not necessarily, have the effect of isolating individuals:
  - The setting is designed specifically for people with disabilities, or for people with a certain type of disability
  - Individuals in the setting are primarily or exclusively people with disabilities and the on-site staff that provides services to them

HCBS CQS July 2018 000296

Settings with the Effect of Isolating Individuals (cont'd)

- Settings that isolate individuals receiving HCBS from the broader community may have any of the following characteristics:
  - The setting is designed to provide people with disabilities multiple types of services/activities on-site such as housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities
  - People in the setting have limited, if any, interaction with the broader community
  - The setting uses/authorizes interventions/restrictions used in institutional settings or deemed unacceptable in Medicaid institutional settings (e.g., seclusion)

HCBS CQS July 2018 000297

Settings with the Effect of Isolating Individuals – Examples

The guidance provides a "non-exhaustive" list of examples of residential settings that have the effect of isolating people receiving HCBS from the broader community. These are listed on the following slides.

HCBS CQS July 2018 000298

Settings with the Effect of Isolating Individuals – Examples (cont'd)

- **A farmstead or disability-specific farm community** that has the following characteristics:
  - Individuals who live at the farm typically interact primarily with people with disabilities and staff who work with those individuals
  - Daily activities and non-home and community-based services, such as medical and religious services, take place on-site so that an individual generally does not leave the farm
  - People from the broader community may sometimes come on site, but people from the farm seldom go out into the community as part of daily life

HCBS CQS July 2018 000299

Settings with the Effect of Isolating Individuals – Examples (cont'd)

- **A gated/secured "community"** for individuals with disabilities that has the following characteristics:
  - The community typically consists primarily of individuals with disabilities and the staff that work with them
  - Locations provide residential, behavioral health, day services, social and recreational activities, and long term services and supports all within the gated community
  - Individuals often do not leave the grounds of the gated community in order to access activities or services in the broader community

HCBS CQS July 2018 000300

Settings with the Effect of Isolating Individuals – Examples (cont'd)

- **Residential schools** that have the following characteristics:
  - The setting incorporates both the educational program and the residential program in the same building or in buildings in close proximity to each other so individuals do not travel into the broader community to live or to attend school
  - Individuals served in the setting typically interact only with other residents of the home and the residential and educational staff
  - Activities such as religious services are held on-site
  - Individuals' experience with the broader community is limited to large group activities on "bus field trips"

HCBS CQS July 2018 000301

Settings with the Effect of Isolating Individuals – Examples (cont'd)

- **Multiple settings co-located and operationally related** (i.e., operated and controlled by the same provider) which congregate a large number of people with disabilities together such that people's ability to interact with the broader community is limited
  - Depending on the program design, examples include:
    - Group homes on the grounds of a private ICF
    - Numerous group homes co-located on a single site or in close proximity, such as multiple units on the same street

HCBS CQS July 2018 000302

Heightened Scrutiny Process

- If a state identifies any settings that are presumed to have the qualities of an institution, the state is obligated to identify them in the Statewide Transition Plan
- The settings regulations require that, in order to overcome the presumption that a setting has the qualities of an institution, CMS must determine that the setting:
  - *Does not have* the qualities of an institution and
  - *Does have* the qualities of a home and community-based setting

HCBS CQS July 2018 000303

Heightened Scrutiny Process (cont'd)

- A state may overcome the presumption that a setting has institutional qualities by **submitting evidence to CMS** demonstrating the setting does not have the qualities of an institution and that it does have the qualities of a home and community-based setting
- When the state submits this evidence to CMS, the state triggers a process known as **"heightened scrutiny"**
- Under the heightened scrutiny process, CMS reviews the evidence submitted by the state and makes a determination as to whether the evidence is sufficient to overcome the presumption that the setting has the qualities of an institution

HCBS CQS July 2018 000304

Heightened Scrutiny Process (cont'd)

Evidence states should submit in a heightened scrutiny process to demonstrate that a setting is home and community-based:

- Evidence should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving home and community-based services into the greater community
- Evidence should not focus on the aspects and/or severity of the disabilities of the individuals served in the setting
- For heightened scrutiny requested under 1915(c) or 1915(i), evidence should also include the information the state received during the public input process

HCBS CQS July 2018 000305

Heightened Scrutiny Process (cont'd)

Submitting evidence for a **setting in a publicly or privately-owned facility that provides inpatient treatment:**

- At a minimum, states should submit information clarifying that there is a meaningful distinction between the facility and the community-based setting such that the latter is integrated in and supports full access of individuals receiving HCBS to the greater community
  - This could include documentation showing that the home and community-based setting is not operationally interrelated with the facility setting
- Examples of such evidence are included in the answer to Question 4 in the June 2015 FAQs

HCBS CQS July 2018 000306

Heightened Scrutiny Process (cont'd)

Submitting evidence for **a building located on the grounds of or immediately adjacent to a public institution:**

- Evidence that a state might want to collect and submit to overcome the presumption of institutional qualities for these types of settings is similar to the evidence for settings in a publicly or privately-owned facility that provides inpatient treatment
- Examples of such evidence are included in the answer to Question 5 in the June 2015 FAQs

HCBS CQS July 2018 000307

Heightened Scrutiny Process (cont'd)

Demonstrating that a setting **does not have the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS**:

- To overcome the presumption that a setting is isolating, a state should provide evidence of the following qualities:
  - The setting is integrated in the community to the extent that persons without disabilities in the same community would consider it a part of their community and not associate the setting with the provision of services to persons with disabilities

HCBS CQS July 2018 000308

Heightened Scrutiny Process (cont'd)

To overcome the presumption that a setting is isolating, a state should provide evidence of the following qualities (cont'd):

- The individual participates regularly in typical community life activities outside of the setting to the extent the individual desires and these activities:
  - Do not include only those organized by the provider agency specifically for a group of individuals with disabilities and/or involving only paid staff
  - Do foster relationships with community members unaffiliated with the setting
- Services to the individual, and activities in which the individual participates, are engaged with the broader community

HCBS CQS July 2018 000309

Heightened Scrutiny Process (cont'd)

Criteria CMS uses to review state requests for heightened scrutiny:

- Whether all of the qualities of a home and community based setting outlined in the federal settings regulations are met
- Whether the state can demonstrate that persons receiving services are not isolated from the greater community of individuals not receiving HCBS
- Whether CMS concludes that there is strong evidence the setting does not meet the criteria for a setting that has the qualities of an institution

HCBS CQS July 2018 000310

Heightened Scrutiny Process (cont'd)

- Tools for states to use in collecting information for CMS' heightened scrutiny process:
  - The Exploratory Questions for Residential Settings and/or Non-Residential Settings (as a framework against which to examine settings)
  - The states' own tools for collecting and evaluating the information received
  - Public input on settings the state has flagged for heightened scrutiny as part of a Statewide Transition Plan or a 1915(c) waiver submission

HCBS CQS July 2018 000311

Heightened Scrutiny Process (cont'd)

- Public notice associated with settings for which the state is requesting heightened scrutiny should:
  - Be included in the Statewide Transition Plan or addressed in the waiver submission to CMS
  - List the affected settings by name and location and identify the number of individuals served in each setting
  - Be widely disseminated

HCBS CQS July 2018 000312

Heightened Scrutiny Process (cont'd)

- Public notice associated with settings for which the state is requesting heightened scrutiny should (cont'd):
  - Include all justifications as to why the setting is home and community-based
  - Provide sufficient detail such that the public has an opportunity to support or rebut the state's information
  - State that the public has an opportunity to comment on the state's evidence
- CMS expects that states will provide responses to those public comments in the Statewide Transition Plan

HCBS CQS July 2018 000313

Heightened Scrutiny Process (cont'd)

Site visits

- To facilitate CMS review of the evidence presented for heightened scrutiny, a state should submit site visit information
- The purpose is to observe the individual's life experience and the presence or absence of the qualities of home and community-based settings

HCBS CQS July 2018 000314

Heightened Scrutiny Process (cont'd)

CMS' response to the state's submission of evidence for heightened scrutiny of a setting:

- CMS will respond in writing as part of its review of the action pending – whether in response to a Statewide Transition Plan, new waiver, or state plan amendment
- CMS will make one of the following determinations:
  - All regulatory requirements are met by the setting in question, or
  - Not all regulatory requirements are met

HCBS CQS July 2018 000315

Heightened Scrutiny Process (cont'd)

CMS' response to the state's submission of evidence (cont'd):

- Not all regulatory requirements are met
  - If the setting is included in the Statewide Transition Plan, the state has several options (see the answer to Question 10 in the June 2015 FAQs)
  - If the setting is included in a new 1915(c) waiver, a new 1915(i) or 1915(k) state plan benefit, or as part of new services added to an existing waiver or state plan benefit, federal reimbursement for services in that setting will not be available until the setting has achieved compliance with all requirements

HCBS CQS July 2018 000316

Heightened Scrutiny Process (cont'd)

CMS' response to the state's submission of evidence (cont'd):

- Approval of a heightened scrutiny request pertains only to the individual setting or settings subject to the request
- Any material changes approved through heightened scrutiny will require the state to update CMS and may result in a reevaluation of the setting
- The state must describe a monitoring process for ensuring that these settings and all settings continue to comply with home and community-based qualities even after the transition period ends

HCBS CQS July 2018 000317

Questions

HCBS CQS July 2018 000318

Sources of Information

Link to CMS HCBS guidance http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html including:

- Federal Regulations: 1915(c) waiver: 42 CFR §441.301(c)(4); 1915(i) State Plan option: 42 CFR §441.710(a)(1); 1915(k) State Plan option: 42 CFR §441.530(a)(1)
- *Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community*
- *Frequently Asked Questions Regarding the Heightened Scrutiny Review Process and Other Home and Community-Based Setting Information* (June 26, 2015)

HCBS CQS July 2018 000319

For More Information

A mailbox to ask additional questions can be accessed at:

hcbs@cms.hhs.gov

HCBS CQS July 2018 000320

HCBS CQS July 2018 000321

VERMONT OFFICIAL STATE WEBSITE

DISABILITIES, AGING AND INDEPENDENT LIVING
Adult Services Division

SEARCH
CONTACT

FEDERAL HCBS REGULATIONS ASSESSMENT AND IMPLEMENTATION PROJECT

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS) (https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving Medicaid funded services have full access to the benefits of community living and are able to receive services in the most integrated setting. As part of Vermont's Global Commitment to Health (GC) (http://dvha.vermont.gov/global-commitment-to-health/vermont-global-commitment-to-health-approval-documents?portal_status_message=Changes%20saved.) waiver, effective January 30, 2015, CMS has asked Vermont to provide assurances in its Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy) that the State's Managed Long-Term Services and Supports (MLTSS) are in compliance with certain aspects of the HCBS rule, specifically those related to the setting requirement and person- centered approaches for service planning.

- CMS HCBS Regulations (https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider)
- Vermont GC Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy)
- CMS 3-Year Extension Announcement (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-09.html)
- CMS Letter to States (https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf)
- CMS Guidance Website (https://www.medicaid.gov/medicaid/hcbs/guidance/index.html)

Program Documents & Tools

HCBS CQS July 2018 000322

- DAIL Provider Self-Assessment Survey (/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf)
- Choices for Care Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_Choices_for_Care.pdf)
- Choices for Care HCBS Reference Table - Home-Based (/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf)
- Choices for Care Reference Table - Enhanced Residential Care (/sites/asd/files/documents/Regulations_Table_for_ERC.pdf)
- Choices for Care Work Plan (updated December 2016) (/sites/asd/files/documents/Choices_for_Care_HCBS_Work_Plan_Revised_December_2016.pdf)
    - DRAFT Case Management Standards Revision (/sites/asd/files/documents/DRAFT_Case_Management_Standards.pdf)
    - DRAFT List of Case Management Standards Changes (/sites/asd/files/documents/Case%20Management%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Adult Day Standards Revision (/sites/asd/files/documents/DRAFT_Adult_Day_Standards.pdf)
    - DRAFT List of Adult Day Standards Changes (/sites/asd/files/documents/Adult%20Day%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Universal Provider Standards Manual Section (/sites/asd/files/documents/DRAFT%20Universal%20Provider%20Standards%20Manual%20Section.pdf)
    - DRAFT Adult Family Care Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Adult_Family_Care_DRAFT.pdf)
    - DRAFT Rights & Responsibilities Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Rights%26Responsibilities_DRAFT.pdf)
    - DRAFT Live-In Care Agreement Form 808 (/sites/asd/files/documents/CFC_LiveIn_Requirements%20808%20Form%20DRAFT.pdf)
    - FINAL Case Management Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf)
    - FINAL Adult Day Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Adult_Day_Standards_January_2017.pdf)
- TBI Program Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_TBI.pdf)

- TBI Program Reference Table (/sites/asd/files/documents/TBI_Reference_Table_HCBS_Regs.pdf)
- TBI Program Work Plan (/sites/asd/files/documents/TBI_HCBS_Work_Plan.pdf)

TAGS:
Human Rights (/tags/human-rights) |
Long Term Services and Supports (/tags/long-term-services-and-supports) |
Medicaid (/tags/medicaid) | Standards (/tags/standards)

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This is a Division of the
Department of Disabilities, Aging and Independent Living
under the Agency of Human Services

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Case Management Standards & Certification Procedures

Older Americans Act & Choices for Care Programs

Revised January 1, 2017

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I. INTRODUCTION

The Adult Services Division (ASD) within the Department of Disabilities, Aging and Independent Living (DAIL) recognizes that quality case management is a critical part of our long-term services and supports system and is crucial to the fulfillment of DAIL's mission. The mission of DAIL is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.

In order to ensure the statewide quality of case management services offered under Older Americans Act (OAA) programs and Choices for Care (CFC), ASD has instituted Case Management Standards and Certification Procedures. The purpose of this document is to establish minimum case management performance standards and to provide guidance for case management agencies and individual case managers. These standards and certification procedures apply to case management services offered under OAA programs and CFC. The Choices for Care Program Manual and Regulations provide more detailed policies and procedures specific to CFC.

DAIL authority to establish service standards and to certify providers of case management services under OAA programs and CFC is established in Vermont state statute, the Center for Medicare and Medicaid Services (CMS) approved Global Commitment to Health 1115 Waiver, and the Older Americans Act.

II. DEFINITIONS

A. **Case Management:** Case management is a professional service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes.

B. **Conflict of Interest:** Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of case management services must maintain a conflict of interest policy that is in line with the standards set by the Centers for Medicare and Medicaid (CMS). See Appendix A for a link to the CMS regulations.

C. **Home and Community-Based Services (HCBS):** HCBS services are person-centered services provided to an individual in their own home or in the home of another person. HCBS services assist individuals to maintain as much independence, community participation, freedom of choice and control over their lives as possible, while preventing the need to live in a licensed facility. The Centers for Medicare and Medicaid Services (CMS) regulates Medicaid funded HCBS services with regards to person-centered planning and settings characteristics.

D. **Modifications:** "Modifications" are any individual-specific exception to the person-centered planning process as required by the federal home and community-based services (HCBS) regulations. Modifications must be documented and include specific elements identified in Section IV. M.

E. **Person Centered Planning:** Person-centered planning is a process for supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning for HCBS services covered under Vermont's Choices for Care program and other similar HCBS long-term services and supports programs. See Appendix A for a link to the CMS regulations.

F. **Quality Management:** Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 124 and

the Vermont Government Accountability Office provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.

G. **Self-Neglect:** Self-neglect is an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs. This definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision (National Adult Protective Services Association).

III. AGENCY CASE MANAGEMENT STANDARDS

All agency policies governing case management activities under OAA and CFC programs listed in the section must be reviewed and approved by ASD. Changes made to the approved policies must be reviewed and approved by ASD prior to implementation.

Case management agencies are expected to be knowledgeable of and in compliance with all relevant state and federal laws and requirements. Case management agencies shall also ensure the requisite case management agency policies are in place, the case management agency is responsible to ensure that all case managers providing services under OAA and CFC programs comply with the ASD Case Management Standards & Certification Procedures and related case management agency policies.

Case management agencies shall have the following written policies and protocols:

A. **After Hour Coverage**: The protocol shall at a minimum ensure that people are able to leave a message with the agency when it is closed.

B. **Consumer Complaint and Grievance Policy**: The policies and procedures shall outline how the case management agency will respond to consumer complaints and grievances. The policies shall address how consumers are informed about agency policies, including the complaint and grievance policy, and will explain how the process works.

C. **Information and Referral Policy**: The policy shall state that the case management agency will accept and respond to requests for information and/or assistance from individuals, caregivers and other third parties.

D. **Mandated Reporting of Abuse, Neglect, and Exploitation Policy**: The policy shall address how the case management agency will respond in cases of suspected abuse, neglect, and/or exploitation of vulnerable adults. The policy must be consistent with the requirements of Vermont statute 33 V.S.A. § 6903 and DAIL policies. ASD shall coordinate review and approval of this policy with Vermont Adult Protective Services, at the Department's Division of Licensing & Protection.

E. **Self-Neglect Policy**: The policy shall define how the agency will serve adults identified as self-neglect. This may include a referral to the AAA (for adults age 60 and older) or the local Designated Agency (DA) for adult mental health services (for adults under the age of 60). In the case of CFC referrals, the case management agency selected by the person shall be responsible for serving the person identified as self-neglecting.

F. **Maximum Caseload Policy**: The policy shall state the maximum caseload size for case managers, the prioritization process for people accessing case management services, and the management of waiting lists for people who cannot be served at any given time.

G. **Case Management Supervision Policy**: The policy shall address how supervision is provided including accessibility of supervisors, review of client records, on-going feedback between the supervisor and case manager and timely performance evaluations of case managers.

H. **Orientation Training Policy**: The policy shall outline the orientation training for new case management staff.

I. **Training Policy**: The policy shall outline ongoing case management training designed to ensure that case managers will have the necessary range of knowledge, skills and abilities to provide high quality case management services.

J. **Quality Management Policy**: The policy shall outline the case management agency's ongoing Quality Management plan regarding case management services. (Refer to Section II. Definitions for a definition of Quality Management).

K. **Conflict of Interest Policy**: At a minimum, the policy shall: (Refer to Section II. Definitions for a definition of Conflict of Interest).
   1. Define conflict of interest,
   2. Describe the agency's process for preventing conflict of interest,
   3. Describe how case managers report potential conflicts of interest immediately with their supervisor,
   4. Describe the agency's process for correcting conflict of interest when it occurs.
   5. Describe that the case manager developing the person-centered plan shall not be any of the following:
      a. Related by blood or marriage to the individual or to the paid caregivers of the individual
      b. Financially responsible for the individual
      c. Empowered to make financial or health-related decision on behalf of the individual
      d. Holding financial interest in an entity that is paid to provide care for the individual
      e. Other limitations as set by CMS and in line with federal rules.

L. **Client Record Policy**: The policy shall include:
   1. The procedure governing their use, storage and removal.
   2. The conditions for release of information contained in the record.
   3. The requirements of authorization in writing by the person or legal representative for release of information.
   4. The maintenance of all records relating to the delivery and documentation of case management services for a minimum of 3 years and the maintenance of all financial records for a period of 7 years.
   5. Compliance with the Health Insurance Portability and Accountability Act.

M. **Background Check Policy**: The policy shall outline the background checks required in order for a person to be employed as a case manager. The policy must be

consistent with the DAIL Background Check Policy.

N. **Emergency Management Plan**: The agency shall have a plan describing how it will identify the critical functions and services it performs that must continue in the event of an emergency and include a plan as to how those functions and services will be provided during that time. The plan shall describe how the agency will collaborate and cooperate with local emergency planners and other local providers. The plan shall also describe how the agency will:

1. Identify persons who might require specific assistance during an emergency; and

2. Provide information and encourage people to develop a personal emergency preparedness plan. Provide assistance in developing the plan as necessary for needed assistance and support in the event of a natural or other emergency which may result in disruption of service

   and/or personal harm. Involvement and consideration of family caregivers, as well as other natural supports must be part of the process.

O. **Agency Confidentiality Policy**: The agency shall have a policy that is no less stringent than the Agency of Human Service Consumer Information and Privacy Rule.

P. **Smoking Policy**: Agency shall have a smoking policy that at a minimum prevents staff from smoking in the presence of people receiving services.

Q. **Limited English Proficiency Policy**: Agency shall have a policy that describes how people with limited English proficiency will be assured meaningful access to services provided by the agency. The policy must comply with federal regulations.

IV. INDIVIDUAL CASE MANAGER STANDARDS

A. The case manager must be knowledgeable of and comply with all agency policies and standards.

B. A case manager shall be knowledgeable about the full range of services available to individuals in their region and shall ensure that individuals are informed of available resources and services. The case manager will make any needed referrals.

C. A case manager shall provide service in an efficient, effective and collaborative manner to avoid duplication of services, unnecessary costs, and administrative tasks.

D. A case manager shall respond to requests for information and/or assistance from individuals in a timely manner.

E. A case manager shall inform all individuals of the agency's grievance procedures.

F. To the extent possible, a case manager shall ensure the person receives person-centered services in the least restrictive and most appropriate setting in accordance with his or her needs and preferences, as required by the U.S. Supreme Court Olmstead decision. (See Appendix A.)

G. A case manager shall recognize self-neglect behaviors and offer intervention, when such behaviors jeopardize the person's wellbeing. For people not enrolled in Choices for Care, a referral shall be made to the AAA (for adults age 60 and older) or the regional Designated Agency for adult mental health (for adults under age 60).

H. A case manager shall respect the person's rights, strengths, values and preferences, encouraging the individual to create, direct and participate in their individualized written person-centered plan to the fullest extent possible.

1. The person may involve a caregiver or a legal representative in decision making. A legal representative may be a legal guardian appointed by probate or family court with specific duties outlined in the court order, an attorney or power of attorney.

2. People have the right to make their own decisions and decide who they want to be involved in decision making. In the event that a person has a guardian or agent, the case manager will involve him/her in accordance with that individual's legal responsibility. When a person does not appear to have the capacity to make decisions and there is no legal guardian or agent the case manager shall refer to the agency policy on self-neglect.

3. The case manager will provide a person-centered process that is timely and occurs at times/locations of convenience to the individual.

4. Person-centered planning must reflect a process that the setting in which the individual resides is chosen by the individual.

5. A case manager shall ensure that a person has the right to receive services under conditions of acceptable risk. "Acceptable risk" is the level of risk an individual and/or his/her guardian, if there is one, is willing to accept after the informed consent process. A case manager may work with the individual and the service provider to develop a Negotiated Risk Agreement when necessary.

I. Assessment: A case manager, with input and participation by the person and his/her support network, shall assess the individual's strengths and needs using the assessment tool(s) approved by ASD.

1. A case manager shall update the assessment at least annually, or at any time there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed.

2. A case manager shall make every effort to assure the completeness and accuracy of the initial assessment and any subsequent reassessments.

3. Assessments need to be completed in compliance with Choices for Care and other program protocol.

J. Goals: When a person requires case management assistance for complex issues the case manager along with the individual and his or her support network shall identify person-centered goals.

K. Planning: Using the information from assessments and in consideration of the individual's person-centered goals, the case manager shall discuss all available options with the individual and his or her support network; and, agree upon strategies built upon the strengths of the individual to achieve these goals. Strategies shall describe the specific service or support to be provided, the person responsible for carrying out the strategies and the target date as agreed upon by the person. The initial goal and strategy identification shall be completed within 60 days of completion of the assessment.

L. Monitoring and reviewing: A case manager shall monitor the delivery of formal and informal services and supports to ensure that services are being provided as planned, to ensure that the person's identified needs are being met, and goals are being pursued. Monitoring shall include regular contact with the individual, caregivers, and service providers. The individuals' goals and strategies shall be updated to reflect the annual reassessment or more frequently if there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed. For more specific guidelines, refer to program and agency requirements.

M. Documentation: A case manager shall maintain current, complete and accurate paper or electronic files for each person including but not limited to:

1. A written release of information or documentation of why a written release of information could not be obtained.

2. The appropriate assessment form designated by DAIL.

3. Person-centered plan which is driven by the individual. The plan must:
   a. Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports the individual's strengths and preferences.
   b. Reflect the setting in which the individual resides is chosen by the individual.
   c. Reflect clinical and support needs as identified through an assessment of functional needs.
   d. Reflect individually identified goals and desired outcomes.
   e. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of paid services.
   f. Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
   g. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
   h. Identify the individual and/or entity responsible for monitoring the plan.
   i. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
   j. Be distributed to the individual and other people involved in the plan.
   k. Include those services, the purchase or control of which the individual elects to self-direct.
   l. Prevent the provision of unnecessary or inappropriate services and supports.

4. Modifications, or exceptions, to the CMS required HCBS person-centered planning process must be documented and include the following: (see definition of Modifications)
   a. Identify a specific and individualized assessed need for modification

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan
c. Document less intrusive methods of meeting the need that have been tried but did not work
d. Include a clear description of the condition that is directly proportionate to the specific assessed need
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
g. Include informed consent of the individual or their legal representative
h. Include an assurance that interventions and supports will cause no harm to the individual.

5. Case notes that shall focus on the individual's progress and any emergent issues that need to be addressed.

6. Other correspondence received or sent which is relevant to individual.

7. Other documents required by specific programs and services, such as copies of applications, notice of decisions, etc.

8. Guardianship/ Power of Attorney and other advanced directives must be documented in the assessment.

9. If the case manager is taking direction from a legal representative, there must be a copy of the legal documentation maintained in the individual's case management record. (e.g. Guardianship or Power of Attorney documents.)

10. Documentation of Negotiated Risk Agreement (if applicable).

11. Documentation of required reporting of suspected abuse, neglect and exploitation.

V. CERTIFICATION PROCESS

A. A case management agency is deemed certified for one to three years by the ASD when the following components have been met:

1. An Area Agency on Aging have a current approved area plan on file with the ASD ora Home Health Agency has received designation to provide Medicare home health services in the State of Vermont by Division of Licensing and Protection (DLP) through the designation or survey process.

2. ASD has completed a certification review.

3. The agency has demonstrated compliance with all requirements found in the Case Management Standards or has shown progress that is acceptable to ASD towards resolving unmet case management standards at time of initial certification or re-certification.

B. The ASD certification process includes:

1. Verification that an Area Agency on Aging has a current approved area plan on file with ASD or verification that a Home Health Agencies has received designation to provide Medicare home health services in the State of Vermont, by Division of Licensing and Protection (DLP) through the designation or survey process.

2. Approval of the policies required in the Case Management Standards.

   a. Policies shall be submitted to ASD in a manner which allows ASD to maintain an electronic file for each agency.

   b. Policies which have been approved as part of the AAA Area Plan process or as part of the Home Health Agency designation do not have to be resubmitted at the time of the initial or recertification process. (See Appendix D for a list of those policies which are included in the Agency on Aging Area Plan or Home Health designation process.)

   c. Policies relating to case management services which have been updated or altered since the previous certification review must be submitted to ASD for approval prior to the certification review process.

3. Review of complaints received and documented at ASD during the past year.

4. Consultation with the following community partners regarding the quality of case management services provided by the agency, as needed:
   - Adult Day providers
   - Waiver Team Members
   - Public Guardians

- Field Directors

5. An on-site review at the case management agency.

   a. Each agency will be notified of the review within one (1) week of the pending on- site visit. ASD reserves the right to make unannounced agency site visits with the intention to conduct a targeted review.

   b. The on-site portion of the review will last for three (3) days but may be extended at the discretion of ASD. It will include:
      - A review of individual CFC and/or OAA case management files.
      - Home-based interviews with individuals who receive case management services through CFC or OAA programs. Interviews may also include family members, surrogates and/or caregivers.
      - Individual interviews with case management staff.
      - Interviews with the Agency Director, Long Term Care Director, and/or Case Management Supervisor(s) to discuss the quality of case management services, the implementation of policies and procedures, and program understanding within the agency.
      - An exit interview with the agency director and others the director may choose to invite. This interview will summarize the preliminary findings of the review.

   c. The review sample will be limited to 4 to 6 individuals participating in High/Highest Needs CFC and/or OAA programs. The sample selection will be announced during day one of the review and may be expanded at the discretion of ASD. Records of other recipients of services may be reviewed as required.

   d. The discovery period of the review process will last no more than fourteen (14) consecutive days. This timeframe may be extended by mutual agreement between ASD and the agency.

   e. A written report addressing the results of the Certification Review will be available to the agency within thirty (30) days from the end of the review process.
      - The written report will consist of a brief letter which states the date of the review under discussion and the Review Grid completed by the DAIL reviewer at the time of the review.
      - A brief statement of particular areas of strength of the agency.
      - A statement of whether all of the Standards were met or not. If any area was not met, the letter will refer the reader to the Review Grid.
      - Any corrective action plan required from the agency must be received by ASD within 15 days from the date the agency received the ASD written report of the results of the quality review.

6. The final review report will have one of the following recommendations.

    a. Three-year certification: No corrective actions or recommendations.

    b. Two-year certification: Granted at the discretion of ASD if the agency's corrective action will bring an unmet standard into full compliance within a month of submittal to ASD.

    c. One-year certification: Granted at the discretion of ASD if the agency's corrective action plan will bring an unmet standard into full compliance after follow-up review visit(s).

    d. Suspension of certification: Granted at the discretion of ASD pending corrective action plan acceptance and follow- up review.

7. Certified Case Management agencies will be listed on the DAIL website. A redacted copy of the certification documents will be available to the public upon request.

8. The following documents will be used as technical references during the Certification Review process:
    a. Case Management Standards & Certification Procedures for Older Americans Act Programs and Choices for Care

    b. Case Manager Training Process

    c. Choices for Care High / Highest Needs Program Manual

    d. Older Americans Act and Accompanying Regulations

VI. APPEALS

The decision to suspend certification or to decertify may be appealed to the Commissioner of the Department of Disabilities, Aging and Independent Living.

1. The agency shall file for an appeal within 10 working days of a notice of suspension or decertification.

2. The Commissioner shall hear the appeal within 45 days of notice from the agency.

3. The Commissioner shall issue her or his decision in writing within 30 days of the hearing.

4. The agency's certification shall remain in place during the appeal process.

5. These deadlines may be increased if agreed to by both DAIL and the case management agency.

APPENDIX A

State and Federal Statutory Authority

I. **State Statute**: The Department of Disabilities, Aging and Independent Living has statutory authority to manage programs and protect the interests of older Vermonters and Vermonters with disabilities within Title 3, Chapter 53, Subchapter 004, Section 3885a of Vermont State Statutes.

The Commissioner has the authority to determine the policies and to exercise the powers and perform the duties required for the effective administration of the Department within Title 3, Chapter 53, Subchapter 003, Section 3052 of Vermont State Statues.

II. **Choices for Care**: Choices for Care is managed under Vermont's Global Commitment to Health 1115 Waiver. The Centers for Medicare and Medicaid Services (CMS) sets parameters for operations and quality management in the Code of Federal Regulations (State Assurances), Vermont's Special Terms and Conditions and Comprehensive Quality Strategy.

III. **Home and Community-Based Services (HCBS) Medicaid Regulations** – New HCBS Federal regulations (2014) set forth new requirements for HCBS settings standards and person-centered planning for people receiving services in home-based settings. The regulations are intended to enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

IV. **Older Americans Act**: The Older Americans Act (OAA) requires the State to be responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all state activities under the Act. Vermont is also responsible for setting specific objectives for each area for all services under the Act. 42 U.S.C.§3025 (a)(1)(c).

Vermont uses Title III-E funds to support case management activities. Vermont is required to establish standards and mechanisms designed to assure the quality of services, and to establish quality standards and mechanisms and accountability. 42 U.S.C.§3030s-1(e)(l).

OAA regulations require Vermont to develop policies governing all aspects of programs operated under Title III and to be responsible for the enforcement for these policies. (45C.F.R.§§1321.11 and 1321.17).

V. **Olmstead Decision**: On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate;

(2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Kennedy, Alice

From: Beth Stern <bstern@cvcoa.org>
Sent: Monday, January 30, 2017 11:10 AM
To: Hutt, Monica; Forkas, Colleen; Tierney-Ward, Megan
Subject: RE: Case Management Standards

Thanks for the update. Interesting times....

beth

From: Hutt, Monica [mailto:Monica.Hutt@vermont.gov]
Sent: Monday, January 30, 2017 9:06 AM
To: Beth Stern; Forkas, Colleen; Tierney-Ward, Megan
Subject: RE: Case Management Standards

Beth, We essentially received confirmation from CMS, acknowledging this as an issue for Vermont but not the direction from them that we had requested. We, through the Secretary's office, did reach out again asking for that direction and they indicated that they would provide it but they are in the midst of a communication ban right now. So nothing new to report at this time. Thanks, Monica

Monica Caserta Hutt, Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401
E-mail: monica.hutt@vermont.gov
http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

"If the spirit of liberty should vanish in other parts of the Union, and support of our institutions should languish, it could all be replenished from the generous store held by the people of this brave little state of Vermont." Calvin Coolidge

---

From: Beth Stern [mailto:bstern@cvcoa.org]
Sent: Friday, January 27, 2017 3:06 PM
To: Forkas, Colleen <Colleen.Forkas@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Case Management Standards

Hi Monica, Colleen and Megan,

Thank you for this. I am wondering if you ever received any response to your letter to CMS from last August regarding Conflict of Interest in Case Management? If so, could you share it with me? Is DAIL still in discussion with CMS regarding this issue?

Thanks!

Beth

From: Forkas, Colleen [mailto:Colleen.Forkas@vermont.gov]
Sent: Tuesday, January 17, 2017 3:28 PM
To: Beth Stern; Carol Stamatakis; J Michael Hall; Janet Hunt; Meg Burmeister; Sandy Conrad (sconrad@svcoa.net); Bean, Marie; George, Camille; Rainville, Kathy; Sara Lane; Tierney-Ward, Megan; B Cody; Barbara Keough; Danell Huntley; Janet McCarthey; Jeanne McLaughlin; Jill Olson; Judy Peterson; Kathy Demars; Lyne Limoges; Nick McCardle; Ron Cioffi; Sandy Rousse; Shawn Tester; Sherry Greifzu; Treny Burgess (trenyb@nchcvt.org)
Subject: FW: Case Management Standards

Sending on behalf of Megan Tierney-Ward

Colleen Forkas
Administrative Services Coordinator III
DAIL/Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-2070
Colleen.forkas@vermont.gov
Phone: 802-241-0294 Mon. Tues. Wed.
Cell: 802-760-8372 Thurs. Fri

Our new central office main phone number is (802) 241-0294 and the fax is (802) 241-0385

"To succeed in life, you need three things. A wishbone, a backbone and a funny bone."

Good afternoon,

As you know, DAIL has updated the Case Management Certification Standards to reflect the new HCBS regulations. The link below will bring you the current standards in place January 2017. I've also included a link to the HCBS Regulations section of our website for your information. Please continue to consult with Stuart Senghas regarding the standards as they relate to your agency's certification.

New Case Management Standards:
http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf
HCBS Regulations Information: http://asd.vermont.gov/special-projects/federal-hcbs

Thank you,

Megan Tierney-Ward
Adult Services Division Director

NEW ASD Website: http://asd.vermont.gov/

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270

Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Forkas at colleen.forkas@vermont.gov. Thank you.

NEED ASSISTANCE?
Contact your local Aging & Disabilities Resource Connection partner:

- Vermont 211: Dial 211
- Senior Helpline: 1-800-642-5119 (for people 60 and older)
- VT Center for Independent Living: 1-800-639-1522 (for people under 60)
- Brain Injury Association of VT: 1-877-856-1772

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Kennedy, Alice

From: Hutt, Monica
Sent: Wednesday, December 06, 2017 8:55 AM
To: Leigh Holliday; Perreault, Liz
Cc: Mohlman, Mary Kate; hannah@heartbeet.org
Subject: RE: Heartbeet Lifesharing CQL Accreditation

See you then Leigh!

Monica Caserta Hutt, Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401
E-mail: monica.hutt@vermont.gov
http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

From: Leigh Holliday [mailto:leigh@heartbeet.org]
Sent: Wednesday, December 06, 2017 8:54 AM
To: Perreault, Liz
Cc: Hutt, Monica ; Mohlman, Mary Kate ; hannah@heartbeet.org
Subject: Re: Heartbeet Lifesharing CQL Accreditation

Hello Liz, Monica, Mary Kate,

Wonderful, we are greatly looking forward to this visit.

See you in January!

Warmly,
Leigh

Leigh Holliday
Licensing and Compliance
Heartbeet Lifesharing, Inc.
218 Town Farm Road
Hardwick, VT 05843
www.heartbeet.org

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strictly prohibited. If you have received this item in error, please notify the original sender and destroy this item, along with any attachments. Thank you.

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On Tue, Dec 5, 2017 at 4:27 PM, Perreault, Liz <Liz.Perreault@vermont.gov> wrote:

Thank you so much! It's all scheduled.

Liz

From: Leigh Holliday [mailto:leigh@heartbeet.org]
Sent: Tuesday, December 05, 2017 2:04 PM
To: Perreault, Liz <Liz.Perreault@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>; Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>; hannah@heartbeet.org

Subject: Re: Heartbeet Lifesharing CQL Accreditation

Hello Liz,

Thank you for reaching out! I would like to confirm that January 24th from 2:00p-3:00p will work great for us. We can meet at the Heartbeet Community Center -- the first building you will see on your way up Town Farm Road. Mary Kate, Monica, we look forward to seeing you both then!

Warmly,

Leigh

Leigh Holliday

Licensing and Compliance

Heartbeet Lifesharing, Inc.

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Hardwick, VT 05843

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On Mon, Dec 4, 2017 at 12:06 PM, Perreault, Liz <Liz.Perreault@vermont.gov> wrote:

Hi Folks,

I have looked at Mary Kate and Monica's schedules to find some time for them to visit Heartbeet. These are the dates and times I came up with for an hour visit (with travel time considered):

1/12/18 3-4

1/24/18 2-3

2/2 Anytime that day, both schedules look pretty open at the moment

Please let me know if you need me to find other dates.

Thank you,

Liz

From: Hutt, Monica
Sent: Friday, December 01, 2017 6:43 PM
To: Leigh Holliday <leigh@heartbeet.org>
Cc: Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>; hannah@heartbeet.org; Perreault, Liz <Liz.Perreault@vermont.gov>

Subject: Re: Heartbeet Lifesharing CQL Accreditation

I will ask liz to suggest some times..... thanks all!

Get Outlook for iOS

From: Leigh Holliday <leigh@heartbeet.org>
Sent: Friday, December 1, 2017 3:31:23 PM
To: Hutt, Monica
Cc: Mohlman, Mary Kate; Hannah@heartbeet.org; Perreault, Liz
Subject: Re: Heartbeet Lifesharing CQL Accreditation

Hello all,

Wonderful! Let's plan for some time in January. Mary Kate, Monica are there days/times that are better for you? We are open to what works best for all.

Warmly,

Leigh

Leigh Holliday

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On Thu, Nov 30, 2017 at 4:43 PM, Hutt, Monica <Monica.Hutt@vermont.gov> wrote:

Happy to visit! At this point, it will probably need to be in January as December is filling up rapidly and I am off from the 22nd into the new year....looking forward to it. Monica

Monica Caserta Hutt, Commissioner

Vermont Department of Disabilities, Aging and Independent Living

Commissioner's Office

HC 2 South

280 State Drive

Waterbury, VT 05671-2020

Telephone: 802.241.2401

E-mail: monica.hutt@vermont.gov

http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

From: Leigh Holliday [mailto:leigh@heartbeet.org]
Sent: Thursday, November 30, 2017 4:20 PM
To: Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>
Cc: Hannah@heartbeet.org; Hutt, Monica <Monica.Hutt@vermont.gov>; Perreault, Liz <Liz.Perreault@vermont.gov>

Subject: Re: Heartbeet Lifesharing CQL Accreditation

Hello Mary Kate and Monica,

What a wonderful idea! Monica has previously been to Heartbeet and has kept up to date with our process as we navigate the Final Rule regarding HCBS. We would love to host both you and Monica at the Heartbeet Community

Center for a continued conversation. I am copying Liz Perreault also on this email, as Executive Assistant at DAIL she may be able to help us with scheduling.

Monica, what would work best for you in terms of finding some time to come to Heartbeet? Perhaps we can look at your schedule as it compares with Mary Kate's availability and put something on the calendar. I look forward to hearing from both of you!

Warmly,

Leigh

Leigh Holliday

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On Thu, Nov 30, 2017 at 10:55 AM, Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov> wrote:

Hi Leigh,

I would love to come out to Hardwick. I would also like to include Monica Hutt, Commissioner of the Department of Disabilities, Aging, and Independent Living, in the visit because of her role and expertise on the topics. I'm cc'ing her here and hoping we can also work with her schedule.

I look forward to it meeting,

Mary Kate

Mary Kate Mohlman, MS, PhD

Director of Health Care Reform

Agency of Human Services

State of Vermont

Phone: 802.585.6605

E-mail: marykate.mohlman@vermont.gov

From: Leigh Holliday [mailto:leigh@heartbeet.org]
Sent: Wednesday, November 29, 2017 4:13 PM
To: Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov>
Cc: Hannah@heartbeet.org; Latour, Ethan <Ethan.Latour@vermont.gov>
Subject: Re: Heartbeet Lifesharing CQL Accreditation

Hello Mary Kate,

Thank you for reaching out! We would love to sit down with you and share more about Heartbeet, the Final Rule regarding HCBS, and our recent accreditation from CQL. It would be wonderful to have you out to Heartbeet for a tour and conversation--would that be a possibility for you? If not we are happy to come meet with you. If you could tell us some dates/times that work for your schedule we will find a time that works. We look forward to meeting you!

Warmly,

Leigh

Leigh Holliday

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On Wed, Nov 29, 2017 at 3:54 PM, Mohlman, Mary Kate <MaryKate.Mohlman@vermont.gov> wrote:

Hello Leigh,

Governor Scott has asked me to reach out to you in follow up to your request to his office. I would be pleased to meet with Heartbeet's team to discuss implications of the Final Rule regarding HCBS, congratulate you on your accreditation by CQL, and learn more about your organization.

Mary Kate Mohlman, MS, PhD

Director of Health Care Reform

Agency of Human Services

State of Vermont

Phone: 802.585.6605

E-mail: marykate.mohlman@vermont.gov

From: Leigh Holliday [mailto:leigh@heartbeet.org]
Sent: Tuesday, November 14, 2017 2:07 PM
To: Delude, Tracy <Tracy.Delude@vermont.gov>
Cc: Hannah Schwartz <Hannah@heartbeet.org>
Subject: Heartbeet Lifesharing CQL Accreditation

Hello Tracy,

This is Leigh from Heartbeet Lifesharing in Hardwick. Earlier this year you helped our team to organize a meeting with Governor Scott and Secretary of Human Services Al Gobeille. We are grateful for your help in making that happen!

We would like to follow up with Governor Scott regarding the steps Heartbeet has been taking proactively as we continue to deal with the implications of the Final Rule from CMS on HCBS Settings. Would you be willing to pass along our letter and press release to his email? We have also sent a copy in the mail.

If you are not the right person to reach out to, could you direct me to the right place? Thank you for your help with this.

Best,

Leigh

Leigh Holliday

Licensing and Compliance

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CMS Initial Feedback on Vermont CQS w/State Response

TOPIC	CMS REQUEST/ISSUE	REFERENCE	PROPOSED RESPONSE	LEGAL or OTHER SUPPORT NEEDED
The Structure of Vermont's STP and Public Comments	Add additional language to the CQS Introduction directing the public to the specific sections and pages related to the home and community-based settings transition plan.	CQS Introduction of Vermont's CQS	Language to be added to the CQS Introduction and Table of Contents that will enable the public to more easily locate and comment on this material.	No
	Clarify if Appendix B was part of the CQS during the public comment period. If the public has not commented on Appendix B, CMS also requests that Vermont notify the public and allow for public comment.	Appendix B of Vermont's CQS	Vermont added an incomplete version of the assessment with their original submission as evidence of their progress to date. A final version of this document was created subsequently – and shared publically.	No
Waivers and Settings Included in the STP	Please clarify settings that were originally under the 1915(c) waiver on the settings listed in the STP and the document's tables.	Table 1 and Table 6 of Vermont's CQS & STCs	[redacted]	PHPG, Legal
	Please include respite care and companion care in Tables 2 and 7, which list the settings that are being examined in the first phase of the CQS.	Tables 2 and 7 of Vermont's CQS	Table edited to clarify that respite and companion care are included in the home based setting.	No
	The CQS also indicates that respite care is provided in foster homes.	CQS	Table 1 and 6 to be modified to change foster home to adult family care.	No

HCBS CQS July 2018 000356

	CMS requests that Vermont provide additional detail on respite care and companion care to clarify if they are provided in home and community-based settings.	CQS	Table 1 and 6 to be modified to change foster home to adult family care.	No
Systemic Assessment:	CMS requests that the state please indicate in the crosswalk if the state regulations comply, do not comply, or are silent with regard to the federal home and community-based settings requirements.	Appendix B	Most recent version of the systemic assessment contains this type of information and will be submitted to CMS	No
	Please cite the specific sections or provide detailed citations of the state regulations and policies that pertain to the federal requirements so that CMS is able to verify the state's assessment of compliance.	Appendix B	Assessment to be edited to include this information.	PHPG
	CMS requests that Vermont expand Appendix B to include any additional settings, whose policies and rules would be part of the state's systemic assessment.	Appendix B Tables 1 and 6 of the CQS	[redacted]	PHPG, Legal
Site-Specific Assessments:	CMS requests that Vermont clarify whether this is a provider self-assessment or if the state's Managed Care Entity (MCE) will conduct an assessment.	Phase 1: "Initiation" Phase 2: "Implementation & Additional Discussion"	The activity referenced in these sections of the CQS is a provider self-assessment.	No
	If Vermont is using a provider self-assessment, please add a description of the validation process that the state will use to confirm the results.	Phase 1: "Initiation" Phase 2: "Implementation & Additional Discussion"	The CQS to be updated to include a description of the validation process that the state will use to confirm the results. Activities to use the existing certification - regulatory site visit process.	No

HCBS CQS July 2018 000357

	CMS requests that Vermont adjust the timeframe to indicate when the state will develop site specific assessment tools and complete the assessments.	Table 3 and Table 8 of the CQS	Site specific assessment tools and assessments will be developed and completed by the end of the first year.	No
Monitoring of Settings:	Please add language that clarifies and describes the overall role of the MCE with regard to the state's home and community-based settings.	CQS	CQS modified to include language that clarifies and describes the overall role of the MCE with regard to the state's home and community-based settings.	No
	CMS requests that Vermont clarify that the state or the MCE will be conducting ongoing monitoring and will ensure settings remain compliant after initial compliance is achieved on March 17, 2019.	Phases 2 and 4 of the STP	The MCE will be conducting ongoing monitoring and will ensure settings remain compliant after initial compliance is achieved on March 17, 2019.	No
Remedial Actions:	Please provide sufficient detail on Vermont's systemic remediation process as well as outline specific remedial actions (e.g., changes to regulations, policies, and licenses and certification) that will address each compliance issue found during the systemic assessment.	CQS Phase 2 Description of Remedial Actions	Phase 2 of the CQS, description of remedial actions, to be modified to provide sufficient detail on Vermont's systemic remediation process as well as outline specific remedial actions (e.g., changes to regulations, policies, and licenses and certification) that will address each compliance issue found during the systemic assessment.	No
	CMS requests that the state describe the process and timeframe (e.g., timeline and interim milestones) for changing these documents identified in the systemic remediation process.	CQS	[redacted]	Legal - Regulations MTW

HCBS CQS July 2018 000358

	CMS requests that Vermont provide details regarding the process and timeline for completing the corrective action plans.	Phase 2	[redacted]	Legal - Regulations MTW
	CMS requests that Vermont provide details on the remediation of all settings (beyond CFC AFC) that must comply with the federal .home and community-based requirements.	Phase 2	[redacted]	Legal, PHPG
	Please clarify in the CQS that full compliance will be achieved by the federal deadline.	In Phase 4: "Maintenance"	CQS to be modified to state that full compliance is to be achieved by March 17, 2019.	No
Heightened Scrutiny:	Vermont should clearly lay out its process for identifying settings that are presumed to have the qualities of an institution; including any additional settings that Vermont may identify that must comply with the federal home and community-based settings requirements beyond the adult family care setting currently addressed in the CQS.	CQS	[redacted]	Legal, PHPG
	Please ensure that the process for identifying settings presumed to have qualities of an institution is applied to all home and community-based settings included in the revised CQS.		The CQS will ensure that the process for identifying settings presumed to have qualities of an institution is applied to all home and community-based settings included in the revised CQS.	No

HCBS CQS July 2018 000359

Relocation of Beneficiaries	CMS requests that the state include a description of a process for relocating beneficiaries from settings that are unable to comply with the federal home and community-based settings requirements.	The four phases in Vermont's CQS	[redacted]	Legal

Public Notice

The Vermont Agency of Human Services (AHS) gives notice that the DRAFT Global Commitment to Health (GC) waiver Comprehensive Quality Strategy (CQS), required by the Centers for Medicaid and Medicare Services (CMS) will be available for public review and comment for a period of 30 days beginning on 08/01/2015 and ending on 08/31/2015. The Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint or road map for Vermont and its contracted Medicaid managed care entity in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In addition to addressing the original GC populations and including Medicaid managed care requirements, the CQS also includes using Medicaid Managed Long Term Services and Supports (MLTSS) as a strategy for expanding home- and community-based services, as well integrating the new HCBS rules published by CMS in March 2014. The new HCBS rules require states to identify their strategies for compliance with the new regulations. Rather than developing a transition plan like other states – Vermont has opted to have the CQS demonstrate the steps required to come into full compliance with the final rule by March 17, 2019 and should suffice as the Statewide Transition Plan. Please see complete draft of the CG to Health Waiver CQS on the DVHA website at http://dvha.vermont.gov/administration/draft-versions-of-state-plan-changes. Persons who are unable to access the Internet may request a hard copy of the DRAFT CQS by calling AHS at (802) 871- 3008.

Public Hearing

There will be a public hearing in which the public is invited to comment on the GC to Health Waiver CQS. The Public Hearing is scheduled for:

August 20, 2015
12:00 p.m. – 2:00 p.m.
Secretary's Conference Room
208 Hurricane Lane, Williston, Vermont

Public may call 877-273-4202; conference room 1262904 for teleconference

Verbal and Written Feedback

Comments may be submitted to Shawn.Skaflestad@vermont.gov At the hearing, the public will have the opportunity to provide both verbal and written comment. A request is made that comments be submitted in written form, as well as voiced, in order to guarantee that they are recorded correctly. Persons who are unable to attend a Public Hearing or submit comments using the Internet, may phone in their comments by calling AHS at (802) 871-3008 or mail written feedback to:

Shawn Skaflestad
208 Hurricane Lane
Williston, Vermont 05495

All comments will be summarized and included with the Comprehensive Quality Strategy as part of the state's submission to CMS.

To: CMS
From:

We are writing to invite your input on Vermont's current processes and standards for service authorization and person-centered planning in the Choices for Care program. We also invite your review of preliminary options under consideration to ensure State and federal standards are aligned.

We understand that federal conflict of interest rules established for 1915 (c) and other similar home and community based service programs limit the ability of a single provider to offer both case management and direct services. However, we are concerned that implementation of these rules in Vermont potentially could compromise program participants' rights to choose their providers, inhibit participants' ability to access necessary care and disrupt the current provider delivery network. Vermont also shares the goal of ensuring conflict free case management. Vermont seeks CMS assistance in developing a policy strategy that aligns HCBS requirements with Choices for Care policies and operations in order to achieve the following objectives:

- Maintain Vermont's commitment to consumer choice and control as a foundational concept of the Choices for Care program
- Ensure that necessary protections are in place to ensure that care planning activities are not influenced by providers' service delivery roles
- Maintain and improve access to person-centered planning statewide
- Support ongoing quality improvement in care delivery
- Sustain Vermont's rural service delivery system
- Maximize use of public resources for care delivery through administrative efficiencies
- Promote integration of LTSS with physical and mental health care as well as Vermont's All Payer Model efforts at delivery and payment reform.

Vermont seeks to work with CMS to align these objectives and mitigate any unintended consequences, including:

- Restriction of participant choice
- Erosion of access to care due to:
    - Loss of comprehensive providers
    - Diminished availability of services resulting from providers discontinuing care coordination or direct care services
    - Disruption of care management services, given the limited availability of staff, during any transition period
- Diversion of funds away from direct services to support a new administrative structure for the provision of case management-only services.
- Increased program costs resulting from different yet overlapping service definitions for case management, care coordination and person-centered planning

We welcome the opportunity to host a CMS site visit to review outcomes data and our ongoing measurement system, tour programs and meet with staff and consumers to discuss how to best respect consumer choice while maintaining alignment with federal rules.

Commented [VT1]: This is an option to consider in promoting how the program differs but not at all necessary.

We are optimistic that Vermont and CMS can partner to develop a solution promotes consumer choice, ensures that services are accessible and sustainable, and provides appropriate safeguards against provider conflict. We look forward to a discussion following your review of the attached materials. Please don't hesitate to contact XXXXXX at XXXXX for additional information and/or questions.

DRAFT

Choices for Care: CMS Discussion Brief and Conflict of Interest Rule Options
Draft June 23, 2016

Choices for Care Program and Participants

In 2005 Vermont opted not to continue several former 1915 (c) waivers for persons with physical disabilities and frail elders, but rather to seek Section 1115 approval to implement a larger reform based on equalizing the entitlement between nursing facility and an array of community based care options. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full consumer choice in when, where and from whom to receive services.

Persons who meet skilled nursing facility level of care (known as Highest and High Needs Groups) are eligible to receive an array of services within the CFC benefit package. The program also includes a limited benefit package for Medicaid and non-Medicaid participants who do not meet, but may be at risk of, skilled nursing facility placement; this is known as the Moderate Needs Group.

Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules that are in the High or Highest Needs Group (i.e., meeting a skilled nursing facility level of care). As of January 2016, 1,826 persons in the Highest and High Needs Group chose skilled nursing facility care, 1,605 persons chose home based supports, and 487 persons chose community residential care. As of January 2016, 1,492 persons received limited benefits as part of the Moderate Needs Group.

Commented [HM2]: Maybe add the %'s here as it represents more than 50% in community

All applicants meet with a State of Vermont Long Term Care Clinical Coordinator (LTCCC) for an initial assessment of eligibility and clinical needs. State staff are also responsible for the authorization of any subsequent change of service once enrolled. Initial meetings include a discussion of service options, providers and a referral for independent options counseling as needed.

Consumers have equal access to an array of traditional state plan services, including skilled nursing facilities, residential care in a PNMI (private non-medical institution) facility, in home and community based options such as companion care, respite and other rehabilitative therapies as well as flexible options for self-managing some or all of their care providers. Final CFC service packages are based on clinical profile, support needs, state plan and unique section 1115 demonstration services.

Choices of Care Providers

Vermont is a small rural state. The State maintains a geographically designated Home Health Agency system, 12 Home Health agencies are recognized in State law/regulation and are required to serve Choices of Care program participants in there catchment areas . One agency is recognized for statewide delivery of services.

In addition, through the Older Americans Act (OOA), the State has five regionally based Area Agencies on Aging responsible for statewide coverage of OOA services. These AAA organizations also provide HCBS companion and respite services under CFC. The full array of CFC services is delivered through:

- 112 Residential Care Homes (PNMI)
- 40 Skilled Nursing Facilities
- 12 geographically designated Home Health Agencies and 1 statewide Home Health Agency with regional offices
- 5 Area Agencies on Aging
- 14 Adult Day Providers
- 10 Specialized Developmental and Mental Health Agencies with expertise in creating highly individualized Adult Family Care placements for persons with complex needs
- 1 Administrative Services Organization for person who self-manage services

Given the rural nature of the State and its small size, no Vermont provider only offers case management services. Due to Vermont's labor market and economic drivers, developing additional provider types has not been economically viable or supported by legislative action.

Once enrolled in the CFC program, a consumer may choose whether to receive on-going case management services from a Home Health Agency or an Area Agency on Aging. Both the HHA and AAA also may provide direct care.

> *Ray lives in his family home; his LTSS supports through the Choices for Care program have included 8 months of Skilled Nursing Facility Care. He currently lives in his family home with his wife and receives 40 hours a week of caregiver time through the Home Health Agency. He also receives companion services through the Area Agency on Aging. His case management choice is the Home Health Agency. Additional supports have been provided through volunteer time from family and friends. Home modifications for wheelchair access have been supported through the Veterans Administration and volunteer labor. Medical follow-up is provided through his primary care physician in the community.*

Case Management Standards and Certifications

The Department of Disabilities Aging and Independent Living (DAIL) conducts periodic quality review and certification of providers designated to provide case management services in the CFC program. Both Home Health Agencies and Area Agencies on Aging undergo certification. In the event that a consumer chooses a case manager who is also affiliated with the provision of one or more services in their care plan, Vermont standards and policies require that conflict of interest issues must be considered and mitigated.

Commented [VT3]: Could consider hyperlink to standards

Person Centered Care and Service Planning Profiles

Unlike typical 1915 (c) programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, acute rehabilitation facilities, home care and adult family care in any given eligibility period. All participants meet skilled nursing facility level of care and may have complex medical profiles, support needs and/or dementia care needs. As such, there is a mix of providers involved in any given service plan. Hospice and end of life care at home are not unusual in the program and services may change rapidly over the course of several months. The average age of a CFC participant is X and the average length of stay in the program is X, with most program terminations due to death of the recipient.

Roger is diabetic with multiple complications of this disease including proliferative diabetic retinopathy of both eyes and renal failure. He undergoes hemodialysis three times a week from 6 am to 9 am. Prior to moving to Adult Family Care placement in the community, Roger was in a nursing facility and was subsequently hospitalized for a heart attack, he developed Ascites, and undergoes a paracentesis procedure approximately every 2 weeks and his needs must be carefully monitored as they can change rapidly. Roger also has SVC venous thrombosis, lymphadenopathy, pleural effusions, pulmonary hypertension, hearing loss, hypertension and a complete heart block. Because he undergoes dialysis, Roger has a dialysis diet and is on restricted fluids. Roger lives in an Adult Family Home in the country he loves rides in the woods, going to the fishing hole and enjoying the view from the pond.

Roger receives case management and caregiver services through a Home Health Agency, is closely followed by his primary care physician. He is living in an Adult Family Care setting hosted through a local agency with specialized expertise in creating individualized living arrangements. All involved agencies and support services were chosen and approved by Roger and his legal guardian.

Outcomes

Prior to the implementation of the CFC Demonstration, 241 persons were on the waiting list for 1915 (c) services. During start up in 2005, all persons were moved from the waiting list. Waiting list counts peaked at 100 persons in 2006 and fluctuated between no waiting list and 80 persons during the recession. Since March of 2011, Vermont has operated the program with no individuals on the waiting list.

The CFC program routinely collects and reviews consumer feedback on experience of care and satisfaction. Periodic consumer surveys show that our consumer's perception of Home Health Agency case manager performance equals or exceeds that of Area Aging on Aging case

managers, and also yields high levels of satisfaction with questions specific to choice and control in the home and community services, including choice of case management agency. A summary of recent data is provided in Table 1 below.

Commented [SW4]: Are comparisons to national statistics available?

Commented [VT5]: Need to discuss which data to use here

Table 1: Choices for Care, Consumer Experience of Care Survey Results

Consumer Survey Question	Consumer Experience of Care	
	Year	Year
Satisfaction with Case Manager Performance		
Satisfaction with Choice and Control		

In addition to direct consumer feedback, the State has advanced a number of independent program evaluations from the University of Massachusetts Medical School that describe general program performance measures and quality outcomes. These can be viewed at the following link: UMASS Evaluations, Consumer Choice and Control

Offering participants full choice based on clinical need has been successful in shifting the balance from skilled nursing facility to community care. In all but three regions the balance is 50/50 with several regions lowering skilled nursing facility care even further. As more participants who require skilled nursing services 24/7 opt to stay at home, the medical complexity of in home care has been increasing, at the same time Vermont has seen a gradual increase in consumers in home and community care options choosing Home Health Agencies as their care manager, from approximately 40% in 2010 to 52% in 2016.

CFC data reports are produced twice a year and can be viewed at: DAIL CFC Data Reports

1915 (c) Home and Community Based Waiver Rules and Conflict of Interest Standards

The State of Vermont understands that consumer choice, coupled with beneficiary protections (e.g., options counseling and provider requirements to address potential conflict of interest) is not adequate to address the requirement in 42 CFR 441.301 (c)(1)-(3) that states:

> *Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process*

Because the Choices of Care program offers consumers the choice of two certified case management providers, the practice may not warrant an exception based on the State's demonstration that "the only willing and qualified entity to provide case management and/or develop person centered plans in a geographic region area also provides in home and community services". Given the unique nature of Vermont's delivery system, the small size of the State and the importance of consumer choice as a fundamental tenet of the program,

Vermont requests continued discussion of options, including the potential for meeting criteria for the "exception" process contemplated in the regulation.

Potential Options and Considerations for Alignment with Conflict of Interest Standards

Vermont staff have begun to identify options for operational changes in the Choices for Care program and would appreciate the opportunity to review these options as well as other potential approaches. Upon narrowing the options in partnership with CMS, Vermont intends to engage stakeholders in a public and intensive planning process. Any change that the State might contemplate will require further discussion with our advisory boards, stakeholder engagement and public comment prior to the State making a commitment on final direction. Options that contemplate new state staff or new entities also will require approval through the State's legislative process during the January – May of 2018 Legislative session. Thus, operational changes would not be expected no earlier than July 1, 2018. Options currently under review with State staff are outlined below and in Table 2 on the following page.

1. **Maintain Beneficiary Choice**: Request CMS exception based on the States demonstration that the HHA and AAA, who provide both direct care and case management services are the only qualified entities for the persons they serve. Enhance Choices for Care program standards including clarification and monitoring of acceptable conflict of interest protections and separation of functions within provider agencies for staff supervision and decision-making for the provision of direct care and case management.

2. **Interdisciplinary Teams to Integrate LTSS/CFC and Physical Health Care**: Advance current planning to strengthen the Integration of LTSS/CFC and Physical Health delivery system as contemplated in Vermont's Health Care Reform Planning. Vermont has had a success with integrated care approaches that connect providers across the care continuum. LTSS stakeholders just began meeting in June of 2016 to discuss how to integrate all aspects of LTSS, Mental Health and Physical Health care into one seamless and integrated delivery system. This could be accomplished through enhancing current Patient Centered Medical Homes (Blueprint for Health); the creation of a Specialized Health Homes; or alignment with a Medicaid Accountable Care Organization (ACO) for consistency across public and private payers.

3. **Create New Entity:** Procure a separate case management provider for regional or statewide service provision.

4. **State Run:** Increase State staff positions to deliver case management services.

5. **Single Provider**: Clearly designate one provider per region and ~~request CMS Exception and~~ request CMS "exception" as contemplated in rule

6. **Separate Corporate Entities**: Encourage current providers to separate lines of business for case management services by creating different corporate entities.

Table 2: Options under Consideration for CMS and Stakeholders

Vermont Options for Addressing Conflict of Interest Policy Standards				
Option	**Considerations**	**Timeline**	**Staff and Budget Impact**	**Stakeholder Impact**
1. Maintain Beneficiary Choice	• Would require CMS determination that provider designations meet the "geographical exception" standard as contemplated in HCBS rule or a determination that the Section 1115 program is distinctly different from typical HCBS programs and therefore exempt • Monitoring may include on-going review of grievance and appeals trends, continuation of consumer surveys and annual quality review and provider certification audits. • The State could also enhance ADRC functions related to independent options counseling prior to choosing a case management agency	Based on CMS review process	Minimal: May result in local agency supervisory structure changes to assure that "firewalls" in chain of command and decision making are in place	Would retain consumer choice while increasing conflict of interest safeguards
2. Interdisciplinary Teams	• Integrated planning has just begun and models for service delivery may not be operational until CY 2018. • Integrated team consist of providers involved in direct care and may not meet CMS requirement to separate functions • May still require CMS determination that integrated care team meets the "geographical exception" standard as contemplated in HCBS rule	TBD Not earlier than July 1, 2018	TBD	Could retain Choice if CMS allowed integrated care team to function as "exception" as contemplated in HCBS rule
3. New Entity	• Would require new legislative appropriation and potential	July 1 2017	• FY2017 Budget Adjustment: Vermont is currently experiencing a revenue	• Will not offer beneficiary choice if only one case

HCBS CQS July 2018 000369

Vermont Options for Addressing Conflict of Interest Policy Standards				
Option	**Considerations**	**Timeline**	**Staff and Budget Impact**	**Stakeholder Impact**
	changes to CFC regulations and program rules • Could add additional layer of administrative infrastructure and divert resources away from direct care • Would meet CMS requirements		short fall of XX and does not anticipate new funds being available before July 1 2017, if at all. • FY2018 Budget Request: Likely to increase program cost as current medical social work and care management currently provided in HHA and AAA would still be required to ensure immediate day to day needs of consumers are recognized, communicated and addressed by separate entity	management provider is available in any given region • Could fragment services if provider is not fully integrated into care team and available for discussion of change in circumstances and/or medical profile
4. Increase State staffing	• Would require legislative approval • Provides safeguards for consumer and ensures non-duplication of services • Could add additional layer of administrative infrastructure and divert resources away from direct care • Would meet CMS standards	July 1, 2017	• Same as option # 3 above	• Same as option # 3 above
5. Designate one provider per region	• AAA and HHA each offer expertise that is important to CFC participants. • May result in destabilization of providers not designated as single entity per region	July 1, 2017	•	• Would eliminate consumer choice • May require current individuals to shift service provision or case management from one entity to another as both currently provide HCBS services and HCBS case management
6. Encourage current providers to create	• Could meet CMS requirements	July 1, 2017	•	• Would continue to allow consumer choice

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HCBS CQS July 2018 000370

Vermont Options for Addressing Conflict of Interest Policy Standards				
Option	**Considerations**	**Timeline**	**Staff and Budget Impact**	**Stakeholder Impact**
separate corporate entities	• Could add additional layer of administrative infrastructure and divert resources away from direct care			

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HCBS CQS July 2018 000371

VERMONT
AGENCY OF HUMAN SERVICES

Report to the Vermont Legislature

Delivery System Reform Report: 2017

Act 113, Section 12; Act 82, Section 7

Submitted by the Agency of Human Services to Senate Health and Welfare, House Health Care, House Human Services.

1-15-2017

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REPORT REQUIREMENTS

Act 113, Section 12 of the 2015-2016 Session requires the Secretary of the Agency of Human Services to embark upon a multi-year process of delivery system and payment reform for Medicaid providers that is aligned with the All-Payer Model and other existing payment and delivery system reform initiatives.

FULL TEXT:

(a) The Secretary of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all Medicaid payments to affected providers and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives.

(b) On or before January 15, 2017 and annually for five years thereafter, the Secretary of Human Services shall report on the results of this process to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services. The Secretary's report shall address:

(1) all Medicaid payments to affected providers;

(2) changes to reimbursement methodology and the services impacted;

(3) efforts to integrate affected providers into the all-payer model and with other payment and delivery system reform initiatives;

(4) changes to quality measure collection and identifying alignment efforts and analyses, if any; and

(5) the interrelationship of results-based accountability initiatives with the quality measures in subdivision (4) of this subsection.

Section 7 of Act 82 of the 2017-2018 legislative session requires a plan to integrate multiple sources of payment for mental and substance abuse services to the designated and specialized service agencies (DAs and SSAs).

FULL TEXT

Act 82, Sec. 7. PAYMENTS TO THE DESIGNATED AND SPECIALIZED SERVICE AGENCIES

The Secretary of Human Services, in collaboration with the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living; providers; and persons who are affected by current services, shall develop a plan to integrate multiple sources of payments for mental and substance abuse services to the designated and specialized service agencies. In a manner consistent with Sec. 11 of this act, the plan shall implement a Global Funding model as a successor to the analysis and work conducted under the Medicaid Pathways and other work undertaken regarding mental health in health care reform. It shall increase efficiency and reduce the administrative burden. On or before January 1, 2018, the Secretary shall submit the plan and any related legislative proposals to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services.

This is the second annual report. The first annual report submitted detailing progress on delivery system and payment reform for Medicaid providers can be found here:

- First Annual Report Filed 1/3/2017: http://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-12-Medicaid-Pathway-Report-12-30-16.pdf

EXECUTIVE SUMMARY

2017 was an exciting year for payment and delivery system reform in Vermont. One of the more significant steps Vermont took was launching a first in the nation pilot payment model where a network of hospitals and providers took on the fiscal responsibility for the care and health of their patients. While this pilot was limited to Medicaid patients, it laid the foundation for expanding this risk arrangement to Medicare and commercial insurers, which is currently underway in 2018. Taking on fiscal responsibility for the health outcomes of patients calls for better coordination of care, more emphasis on prevention, and the necessary bridging of services across the care continuum to accomplish the first two goals.

Medicaid as a payer has an integral role in shaping payment reform and supporting delivery system reform. Under the authority of the Global Commitment to Health, the Medicaid 1115 waiver that gives Vermont additional flexible in the way it uses its Medicaid resources, Vermont has pursued new payment mechanisms, covered services not traditionally reimbursable through Medicaid, and implemented programmatic innovations such as Blueprint for Health, Hub and Spoke, and Choices for Care. As Vermont continues to build on its previous successes in health care reform, AHS, through its constituent departments, has prioritized shifting from fee-for-service, which incentivizes volume of care, to value-based payments and care, which emphasize better health outcomes and sustainable costs. In addition to the Medicaid risk-based pilot, AHS has partnered with the accountable care organization OneCare Vermont to develop improved care coordination and integration of services, and the Department of Mental Health is developing alternative payments for services provided to children and to adults.

As part of this process, AHS recognizes that the success of payment and delivery reforms relies on a strong foundation. This solid foundation must include equitable payments, accountability for the services rendered, and data by which the first two can be supported and assessed. AHS has taken steps around payments by increasing reimbursement rates for primary care, reconciling in-state and out-of-state hospital rates, and realigning Federally Qualified Health Center payments with federal law. Regarding accountability, AHS, and specifically the Department of Disabilities, Aging, and Independent Living, are working to improve the accounting of payments paid and services delivered within the developmental services system. Knowing the actual costs of the services and having sufficient information to ensure the quality of the services are important precursors to reforming how AHS pays for the services. Finally, AHS is working to improve how data is collected and managed across the Agency through a new governance system.

Act 113, Section 12 requires the Secretary of the Agency of Human Services, in collaboration with the Director of Health Care Reform and the Green Mountain Care Board to create a process for payment and delivery system reform for Medicaid providers and services and to report on these activities. Act 82, Section 7 asks the Secretary of the Agency of Human Services, in conjunction with Commissioners of the Departments of Mental Health and Disability, Aging, and Independent Living to submit a plan for reforming payments made to the designated agencies and specialized service agencies for mental health and substance use disorder services. The Agency believes that the content of the Act 82, Section 7

report falls within the payment and delivery system reforms requested in Act 113, Section 12, and therefore has been integrated into this report.

The following report, ~~servicing~~ serving as the second annual report required by Act 113, Section 12, reviews in greater detail the progress the AHS has made towards shifting to value-based payments, improving integration across the continuum of care, and improving accountability.

SECTION 1: INTRODUCTION

The year 2017 brought substantial transition for state government in general and health care reform specifically. In additional to a new Administration and significant leadership change in the General Assembly, Vermont embarked on the implementation of two new agreements and the extension of a third:

1) The Vermont All-Payer Accountable Care Organization (ACO) Model Agreement (APM Agreement) with the Centers for Medicare and Medicaid Services (CMS);
2) A Medicaid contract with OneCare Vermont ACO LLC (OneCare), which established a pilot Next Generation ACO model for approximately 29,000 Vermont Medicaid beneficiaries; and
3) The Global Commitment to Health Medicaid 1115 Waiver, which gives Vermont the ability to be more flexible in the way it uses its Medicaid resources such as new payment mechanisms, coverage of services not traditionally reimbursable through Medicaid, and programmatic innovations.

Through these agreements, Vermont has the opportunity to shape how we pay for and deliver health care in way that is tailored to Vermont needs and improves alignment across payers, including Medicare, Medicaid, and commercial insurers. Collectively, these efforts have the goal of better health, better quality care, and affordable and sustainable health care costs. Furthermore, the changes in payment for and delivery of care that Vermont is pursuing creates incentives to focus on primary and preventive care and to create more alignment between medical, mental health, substance use disorder, and social services. These reforms recognize that health is not limited to the doctor's office, but begins where we work, play, and live.

Under the previous administration, efforts began to introduce payment and delivery reforms to Medicaid-funded programs, including services provided by the Designated Agencies (DA's), Specialized Service Agencies (SSA's), and preferred providers of substance use disorder services. This work occurred through the Medicaid Pathways initiative, which was launched by the Agencies of Human Services (AHS) and the Agency of Administration (AOA) in the Fall of 2015. However, under the incoming Scott Administration, the focus for 2017 shifted to establishing the Vermont Medicaid Next Generation (VMNG) ACO pilot model and to prepare for expanding ACO-based reform to Medicare and commercial insurers as well and expanding the number of hospitals, providers, and Vermonters engaged. Furthermore, while a report produced by Burnes and Associates for the Medicaid Pathways project reviewed multiple~~y~~ payment reform models for DAs and SSAs, it also identified a number of challenges that currently incumber implementation. For example, payment reform for DAs and SSAs would benefit from standardization around data quality, consistency, and collection; standardization in reimbursement

and billing guidelines; and better readiness for operationalizing reforms. [cite] As another example of the current challenges to payment reform, a 2014 report by the State Auditor on DA and SSA budgets [cite] found insufficient data on developmental disability services to confirm whether services paid for through inclusive payments were actually delivered to the individual. While this finding should be addressed regardless, it also has significant impacts on payment reform. Successful payment reform cannot proceed without parties involved having a clear understanding of the actual services being delivered, an accurate cost of these services, and the quality of the services. A current review by DAIL of service delivery, accountability and reporting mechanisms~~this by DAIL~~ is currently underway.

Despite these challenges, AHS, using the lessons learned through the Medicaid Pathways process, continues to pursue the goals of a more integrated health care system across the care continuum and the creation of value-based payments. These pursuits are in-line with AHS's strategic goals [is there something to cite?] and responsibilities under the APM Agreement. In addition to efforts at the state level, OneCare's recently approved budget for Year 1 of the agreement also supports a care model that integrates care across multiple organizations and employs alternative payment mechanisms.

The following report outlines 2017 work that occurred to support payment and delivery system reform with the goal of a more integrated health care system.

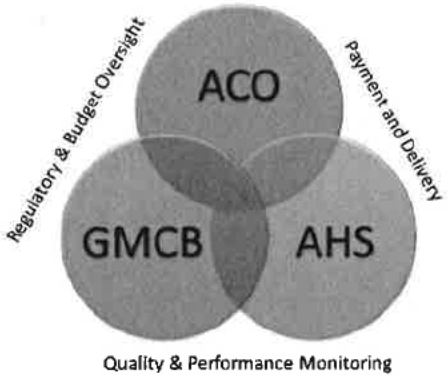
SECTION 2: ACO-BASED REFORM

While AHS would likely pursue Medicaid payment reforms that incentivize increased integration and alignment across the care continuum and have the goals of high-value care and sustainable health care costs, the APM Agreement and ACO-based reforms are the current vehicles through which these reforms occur. As such the priority for 2017 has been to operationalize the provisions of the APM Agreement.

ROLES AND RESPONSIBILITIES UNDER THE APM AGREEMENT

The APM Agreement identifies AHS and GMCB as the key state entities charged with carrying out the responsibilities laid out in the agreement. Specifically, GMCB is tasked, in collaboration with AHS, with monitoring how the model is achieving financial, quality, and outcome targets. The General Assembly, through Act 113, supported this role by granting GMCB regulatory authority over ACOs including approval of their budgets. AHS, in collaboration with GMCB, is tasked with creating the conditions in which the ACO can begin to improve coordination across the care continuum. The ACO accordingly has the role of engaging multiple payers (i.e., Medicare, Medicaid, and commercial insurers) to establish alternative ways of paying hospitals, medical providers, and community providers. Figure 1 describes these relationships.

Figure 1. Key Relationships under the APM Agreement



Additional Actors: Legislature, Centers for Medicaid and Medicare Innovation, Medicare, Medicaid, commercial insurers

VERMONT HEALTH CARE REFORM

To carry out the responsibilities under the APM Agreement, AHS Central Office, DVHA, including Blueprint for Health, and GMCB meet regularly to review how respective activities are aligning, for example, how progress on developing the VMNG contract coordinates with GMCB's review of the ACO budget. Additionally, AHS staff and Commissioners of the Department of Disabilities, Aging, and Independent Living (DAIL), Department of Mental Health (DMH), Vermont Department of Health (VDH), and Department for Children and Families (DCF) meet with OneCare regularly to review how OneCare's delivery system reforms align with AHS services. Examples agenda items include screening tools used, quality and performance measures, LTSS, etc. GMCB works with OneCare in its oversight capacity to ensure the ACO is meeting its requirements for certification and operates in compliance with its budget order.

Finally, an agency-wide group met regularly in the first part of the year to review how the work in each of the departments in AHS intersect with the other departments and with the health care system. This group provided valuable level-setting around AHS services and identified common themes across departments. One of these themes was the continual struggle to capture acute care or service dollars and invest them in preventive services that could avert the need for expensive acute care down the road. One of the goals for payment reform is to address this concern. Moving forward, this cross-agency group will work to ensure that AHS fulfills its role in the APM Agreement in a coordinated way.

APM EXPECTATIONS FOR ALIGNMENT AND INCLUSION OF ADDITIONAL MEDICAID SERVICES

The APM Agreement's initial focus is on hospital and physician services. DVHA's VMNG ACO Pilot program with OneCare was the first step in operationalizing the goals and provision of the agreement. In 2018, OneCare has extended the VMNG another year, is including Medicare and BlueCross BlueShield of Vermont (BCBSVT), and expanding to additional communities. However, the APM Agreement also calls out the need to include other services necessary to achieve the population health and quality outcomes over the period of the agreement. These services include mental health, substance use disorder, home- and community-based services, and long-term institutional services. The agreement also calls for close

monitoring to ensure the ACO is investing in community-based services such as Blueprint for Health community health teams and preventive services.

Expanding services will involve strategic planning in collaboration with OneCare and GMCB. By December 31, 2020, the state must have developed two plans: one involves coordinating financing and delivery of Medicaid mental health and substance use disorder services with the APM Agreement financial and quality targets; the second involves coordinating the financing and delivery of Medicaid home- and community-based services with APM Agreement targets. Beginning on January 1, 2021, Medicaid Long-Term Institutional Services will be included in the APM Agreement as financial target services.

While these deadlines are still a couple years away, initial planning and preparation has already begun. These efforts are summarized in Section 3.

DELIVERING COORDINATED, HIGH-VALUE CARE

In the Medicaid Pathways project, much of the work was guided by the following principles, which made up the Vermont Model of Care:

1. Person /Family Centered and/or Directed Services and Supports
2. Access to Independent Options Counseling & Peer Support
3. Involved Primary Care Physician (PCP)
4. Access to Specialized Services
5. Lead Care Coordinator (Single Point of Contact)
6. Medical Assessments and Disability and LTSS Screening by PCPs, Medical Specialists
7. Disability and Long-Term Services and Support Specific Assessments
8. Comprehensive Care Plan (including a Shared Care Plan)
9. Individual Care Team (ICT) and Care Conferences
10. Support During Care Transitions
11. Use of Technology for Information-Sharing

Prior to the Medicaid Pathways, Integrated Community Care Model (ICCM) Learning Collaborative, which established many of the above principles, was launched in 2014 by Blueprint for Health, GMCB, the three ACOs, and VHCIP staff with support from VHCIP funding. The ICCM Learning Collaborative brought in experts from across the country to work with Vermont organizations to systematically identify individuals and families who would benefit from cross-organization, team-based care. The Learning Collaborative also supported a common set of tools to engage people in their care, brought together providers working with each identified patient in patient-centered teams, developed shared-care plans based on the patient's goals and abilities, and supported communication among team members for more complete, effective, and efficient care and better patient outcomes. Communities used existing local infrastructure including project managers, quality improvement facilitators, and community health teams to support the model.

The ICCM Learning Collaborative has served as the foundation for the care model currently used by OneCare. This care model uses data to identify health risks across the population, dividing people into

four progressively more intense levels of care, implementing community wide prevention strategies, supporting self-management of health conditions, and proactively targeting services to individuals who need them most. In support of the care model, OneCare has implemented a payment structure that supports team-based care, share care plans, and a lead care coordinator. For more information on OneCare Vermont's population health initiatives and payment reforms, see provisions 29-43 in the GMCB's FY18 Accountable Care Organization Budget Order.[include citation/link]

As part of the collaboration between OneCare and AHS, departments have begun to explore how their services align with the Care Model and how to improve coordinated services.

Around the same time the ICCM emerged, VHCIP funding supported a new model of collaborative leadership for population health improvement work, called Accountable Communities for Health. Like the ICCM work, the first step was a year-long learning collaborative. The Accountable Communities for Health Learning Collaborative engaged management- and leadership- level staff from across the spectrum of health care and community service organizations, including mental health, substance use disorder treatment, home health, aging services, food banks, housing organizations, transportation companies, and more. The participating groups from each community often emerged from the Community Collaboratives that are supported by the Blueprint for Health, ACOs, and the Vermont Department of Health. The Accountable Communities for Health Learning Collaborative gave these groups an opportunity to develop or refine their work in nine core areas: Mission, Multi-sectoral Partnership, Integrator Organization, Governance, Data and Indicators, Strategy and Implementation, Community Member Engagement, Communications, and Sustainable Financing. Many Community Collaboratives found this framework so useful that they formally adopted it as their strategy for improving the health of the population in their region. Some have also begun calling their Community Collaboratives "Accountable Communities for Health." These multi-disciplinary population health leadership bodies guide and monitor improvement work in their communities related to care management, prevention and healthy living initiatives, self-management programs, cross-organization clinical quality improvement, substance use disorder and mental health services, and other locally-determined priorities.

SECTION 3: 2017 DEPARTMENTAL REFORM INITIATIVES

CMS RECOGNITION OF 7 NON-FEE FOR SERVICE PAYMENT MODELS

One of the goals of implementing the Global Commitment to Health demonstration is to improve the health status of all Vermonters by promoting delivery system reform through value-based payment models. As per the Special Terms and Conditions of the currently approved Global Commitment to Health Medicaid 1115 waiver demonstration, AHS must submit certain non-fee-for-service payment models to CMS for approval prior to implementation. To ensure consistency with the state's health care reform vision, all proposed payment models must advance at least one of the goals and objectives in the Global Commitment to Health Comprehensive Quality Strategy (CQS) and use a common set of performance measures across all providers.

During negotiations to extend the Global Commitment to Health waiver in 2016, Centers for Medicaid and CHIP Services (CMCS) and Vermont recognized that the Vermont Medicaid program has made

efforts under its demonstration to implement delivery system and payment reforms. Both parties then performed an inventory of payment models that are authorized through the waiver and outside of the Vermont Medicaid State Plan. As a result of the inventory, CMCS and AHS identified 7 existing non-FFS payment models for future review and approval by CMCS:

1. Vermont Medicaid Next Generation ACO
2. Blueprint for Health- Patient-Centered Medical Home
3. Blueprint for Health- Community Health Teams
4. Blueprint for Health- Women's Health Initiative
5. Dental Incentive Payment
6. Children's Integrated Services
7. Integrating Family Services

These models demonstrate progress through the Vermont Medicaid program to implement alternative payment model approaches that are supportive of delivery system reform. Each of these payment model applications were reviewed to ensure that they were representative of the array of services provided and of the diversity of individuals served as well as aligned with the broader demonstration goals and objectives. As of the date of this writing, all payment models have been approved by CMS.

DEPARTMENT OF VERMONT HEALTH ACCESS

PROGRESS ON VERMONT MEDICAID NEXT GENERATION ACO PILOT PROGRAM

The VMNG ACO pilot, as one of the approved payment reform models, represents the initial phase of Medicaid's participation in the integrated health care system envisioned by the APM Agreement. In February of 2017, DVHA contracted with OneCare to launch the VMNG Pilot program for the 2017 calendar year with four optional one-year extensions. The model's goal is an integrated health care system with incentives aligned to improve quality and reduce unnecessary costs. The VMNG ACO Pilot program pursues this goal by transitioning how we pay for care from fee-for-service payments to value-based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

Through the VMNG Pilot program in 2017, DVHA partnered with OneCare to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. OneCare's network of participating providers includes the University of Vermont Medical Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital along with their employed physicians and providers. It also includes two Federally Qualified Health Centers; independent practices; home health providers; Designated Agencies; Area Agencies on Aging; and skilled nursing agencies in the four participating communities.[1] Together, DVHA and OneCare are piloting a financial model designed to support the clinical and operational capabilities of the ACO provider network with the goal of supporting health care professionals deliver the care they know to be most effective in promoting and managing the health of the population they serve.

[1] See https://www.onecarevt.org/NetworkParticipants.

The VMNG ACO Pilot program was designed to support the implementation of Vermont's APM Agreement. Most notably, the included services, attribution, and payment methodologies are aligned with the Medicare Next Generation ACO program, including all-inclusive population-based payments. Through the VMNG, DVHA pays OneCare a monthly per member fixed prospective payment for services closely corresponding to Medicare Part A and Part B services that are provided by hospitals (and hospital-owned practices) participating with the ACO. The OneCare is responsible for both the cost and quality of care for each attributed member, regardless of how much care that person uses. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. Beyond payment, the majority of quality measures align with the APM Agreement. In accordance with Act 25 of 2017, DVHA submitted updates on the VMNG ACO Pilot on June 15, September 15, and December 15, 2017.

DVHA and OneCare elected to exercise one of the four optional one-year extensions permitted by the VMNG contract. A one-year extension enables DVHA and OneCare to continue the program for the 2018 calendar year. DVHA and OneCare highlighted several mutual goals for a 2018 performance year when entering into negotiations:

- Minimize programmatic changes from 2017 to 2018 to provide stability for ACO-based reform as commercial and Medicare Next Generation ACO programs begin.
- Increase the number of communities voluntarily participating in the program.
- Increase the number of Medicaid beneficiaries attributed to the ACO.
- Ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2018 per the requirements of the APM Agreement.

Negotiations concluded during the fourth quarter of 2017, and the final contract was signed by the Commissioner of DVHA and the CEO of OneCare on December 29, 2017.
The contract covers _____ Medicaid enrollees in 10 communities.

Commented [MMK1]: nything else? Do we want to call out VMNG support of the care model?

DVHA PRIMARY CARE PAYMENTS

In addition to changing how Medicaid pays for care, DVHA recognizes the importance of primary care in supporting the delivery system reforms needed to response to payment reforms. One way to support primary care is to create equity between Medicare and Medicaid for primary care rates. DVHA has achieved this goal by aligning payment for certain primary care codes with Medicare through its recent update to its physician fee schedule and primary care incentive payments, which became effective August 1, 2017.[2] Specifically, DVHA increased the rate paid to eligible primary care providers for certain services to equal the Medicare calendar year 2017 payment rates.[3] This increase is achieved by using a special conversion factor (CF), which was formerly called an Enhanced Primary Care Payment, or EPCP.

[2] Vermont's Global Commitment Register (GCR) provides information on Vermont Medicaid policy changes. GCR 17-061 contains information on these primary care payments. See http://dvha.vermont.gov/global-commitmentto-health/global-commitment-register.

[3] The Vermont Medical Society's comments to this proposed change listed creating equity with Medicare payments as a "major public policy milestone."

For more information on this accomplishment, review DVHA's *Vermont Medicaid Payment Alignment Report, Act 85 of 2017.*[4]

DARTMOUTH-HITCHCOCK MEDICAL CENTER SETTLEMENT

[Insert text here]

FQHC PAYMENT RECALIBRATION

[Insert text here]

DEPARTMENT OF DISABILITIES, AGING, AND INDEPENDENT LIVING REFORM INITIATIVES

DAIL was an active participant in the Medicaid Pathways project. During the process, two "cohorts" were identified, both of which included population overseen by DAIL. The first cohort included Specialized Medicaid Programs and Services within AHS Mental Health (MH), Developmental Disabilities Services (DDS), and Substance Use Disorder (SUD) Treatment Services. The second cohort included Choices for Care (CFC) and traumatic brain injury (TBI).

While the work on these cohorts specific to Medicaid Pathways has ended, DAIL continues to explore reforms to how Medicaid pays for services such that the payment rewards high quality, high value care instead of volume. The below describes these activities. As mentioned above, a cross-agency group, the Delivery System Reform Work Group, met regularly from the beginning of the year to engage in level setting around the Agency's programs and populations served. DAIL presented overviews of current LTSS (CFC, DDS, TBI) laws, rules, eligibility, provider system, services, reimbursement, quality management, outcome and performance measures. DAIL continues to participate in this group as AHS develops a workplan around aligning LTSS with financial and quality targets of the APM Agreement.

Additionally, in line with a recommendation from the previous CFC Medicaid Pathway group, DAIL convened a DAIL Advisory Board subgroup in May of 2017 to work on redesign of CFC Moderate Needs Group (MNG) payment and services. This group has met and produced draft recommendations for changes to CFC MNG eligibility and reimbursement methodology. Some preliminary recommendations from the group include:

- Expand the flexible funding option versus provider specific allocations;
- Allow provider carry forward of unspent allocation from one fiscal year to the next;
- Change eligibility standards to more accurately target intended population;
- Change wait list standards from chronological to need based.

DAIL also convened a group in the fall of 2017 to work on the redesign of DDS payment and services. The workgroup is focused on exploring a new payment ~~models~~ structures to ~~streamline procedures and~~ enhance transparency and accountability for Home and Community-Based Services for ~~adults~~individuals with developmental disabilities. ~~Furthermore~~, This work is essential to establishing the foundation for informed payment reforms and will continue in 2018 with a heightened focus on accountability for service delivery, identification of costs to ensure a stable provider system and a standardized rate

[4] https://legislature.vermont.gov/assets/Legislative-Reports/Medicaid-Alignment-Report-to-Legislature-FINAL.pdf

Commented [MMK2]: etting aside since I'm not sure where this fits in anymore

1. Preserve and strengthen the successes of the Choices for Care program. Choices for Care has been nationally recognized for its innovation in LTSS. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full consumer choice in when, where, and from whom to receive services. Unlike traditional LTSS programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, home care, adult day services, and adult family care in any given eligibility period. The seamless nature of services and strong support for participant-directed care and service delivery must be preserved.
2. Foster on-going meaningful input into the reform process through continued consumer, stakeholder and provider dialogue.
3. Ensure informed consent, privacy, confidentiality, and appropriate release forms regarding information sharing, and especially among interdisciplinary team members.

structure across the state. The goal is to develop a new structure for the delivery and payment of services to individuals by the beginning of SFY 19.

Commented [MMK3]: o we have any more detail around this?

For services for children with developmental disabilities and their families, the Developmental Disabilities Services Division (DDSD) has been meeting with the Department of Mental Health (DMH) Child, Adolescent and Family Unit to explore further integration of services across the departments and at the local level. DMH and DDSD staff visited a number of Designated Agencies, who have moved forward with integrating their services for children and families. Staff identified common themes across these agencies due to integration that included following:

- Previously distinct eligibility rules restricted access and flexibility of services. Removing those opened access so more children could be served.
- Blended funding allowed a partnership between DDS/MH that created an essential culture change of working with children and families to identify the most appropriate combination of support and treatment. The changes freed up clinicians and other staff to focus on service delivery.
- Agencies no longer needed funding work-arounds for children and families to receive services.
- Agencies could tailor how services were delivered to meet unique needs of a community.
- Improving the focus on natural supports and connections to community allowed agencies to maximize efficiencies in service delivery.
- DDS and MH recognized each had skills to bring to the service delivery for a family such as clinical mental health services, family systems work, and skill development.

DDSD and DMH continue to meet to explore expanding more integrated services to more regions of the state. This work will be ongoing in 2018.

DAIL has also begun internal work to create a list of 'strengths' and 'opportunities' across DAIL LTSS, intended to inform broader reform work across CFC, DDS, and TBI.

In support of implementing the APM Agreement, OneCare invited DAIL (along with other providers and stakeholders) to participate in developing policies and procedures to implement the APM waiver of the Medicare requirement for a qualifying 3-day hospital stay before Medicare coverage of nursing facility services. Draft procedures and workflow have been developed. As of this writing, the work of this group continues.

Finally, DAIL has begun initial conversations with ~~other~~ internal stakeholders about possible changes to Medicaid rate setting and reimbursement for nursing facilities. The AHS Division of Rate Setting has direct responsibility for the current payment regulations and procedures.

DEPARTMENT OF MENTAL HEALTH REFORM INITIATIVES

The DMH is working with the DVHA Payment Reform team and in coordination with the Director of Health Care Reform to develop new payment models for reforming child and adult mental health reimbursement. The new payment structures under development are in alignment with alternative and value-based purchasing approaches. The goal is to create models that can include other AHS

departments over time, that will align with payment approaches through the APM Agreement, and that give providers the flexibility they need to implement effective service delivery approaches.

Work is currently underway in both programs, with the goal that each follow similar paths; however, the work on the children's program began earlier and has progressed farther. The target for implementing both programs of service is FY19, but that date may change to achieve the desired scope of reforms rather than reducing scope to meet a fixed timeframe.

The structure of the children's payment reform approach is depicted in the figure below. The Children's Change Workgroup oversees the process with three sub-groups focused on different components of the work (payments, quality, and operations). All workgroups are facilitated and supported by DVHA's Payment Reform team with representation from DMH (including the former Integrating Family Services Director), the Designated Agencies, and Vermont Care Partners. Depending on scope and capacity, other Departments may join the effort over time.

Figure 2. The Children's Mental Health Reimbursement Reform Organization

The DVHA payment reform team, Designated Agency representatives, and Vermont Care Partners serve as the bridge from the child mental health work groups for overlapping information and developmental milestones to inform the recently launched adult payment reform work groups.

The Children's Change Workgroup has reviewed lessons learned from the Integrating Family Services pilot regions to capitalize on effective strategies realized in these pilots and to learn from the challenges of that initiative. Work from the Medicaid Pathway has also been reviewed and incorporated into the planning where relevant, including topics such as the Vermont Model of Care, organization of the delivery system and governance expectations aligned with integrated delivery models; payment models that support value-based and population health approaches; quality and performance measurement to support value-based payments; and alternative payment models for services delivered by Designated and Specialized Service Agencies.

The Children's Change Workgroup has identified the following goals for defining a payment reform model aligned with the Triple Aim:

- Sustainable spending
  - Simplify funding streams
  - Move away from fee-for-service reimbursement
  - Increase payment predictability
  - Increase flexibility for providers
- Better Care (i.e., improved customer experience)
  - Improve access to care
  - Improve satisfaction
  - Strengthen Children's System of Care
- Healthier People (i.e., improved outcomes and value)
  - Streamline outcomes
  - Improve efficiency of quality review processes
  - Focus on improving health across a population

The Children's Payment Model & Methodology Work Group is tasked with identifying and developing an attribution methodology, the scope of services to be included, a financial methodology, and the provider payment mechanism. To date, the workgroup has identified a preliminary set of core services and funding streams to be included in the payment model. These services require more analysis and broader stakeholder input in order to be finalized, additionally, several funding streams have interagency linkages and have been identified for Commissioner review at the beginning of CY 2018. The next steps of this work group are to identify the most appropriate value-based purchasing methodology and management of risk. A key principle for the model is that it is flexible enough to adapt to needs of a community.

The Children's Operational Considerations Work Group intentionally began later than the Payment Model and Quality workgroups to allow some initial development of the payment model and measures. The group has begun to identify the current rules, policies, procedures, guidelines and manuals that relate to the proposed funding streams and services. Activities related to program integrity functions are being explored to determine what processes will be needed to support the new model and the workgroup is also considering developing internal DMH and provider agency readiness assessment tools as both DMH and the agencies will need to consider internal staffing roles and responsibility changes.

The Children's Quality & Value Component Work Group is looking at quality management and indicators, performance reporting, and information systems. See section 4 of this report for more information.

Due to its recent launch, there is no additional information about the design and development of Adult Mental Health payment and delivery reform models to be added to the report at this time.

SECTION 4: QUALITY MEASURE COLLECTION AND RESULTS-BASED ACCOUNTABILITY

DATA GOVERNANCE

Data plays a key role in supporting program operations, devising reform strategies, informing continuous quality improvement, and evaluating the efficacy of program and reform efforts. As such, AHS has committed to increasing the use of cross-agency data, improving the information technology (IT) that supports the data, and establishing a governance structure to provide essential leadership and decision making around data and health IT.

[Do we have anything on governance structure? Examples of work either internally or with external stakeholders (i.e., DAs)?]

COMPREHENSIVE QUALITY STRATEGY AND OTHER EFFORTS WITH DEPARTMENT QUALITY REPS

Commented [MMK4]: ??

During 2017, AHS continued to enhance alignment within and among the various health care reform initiatives. While the performance measures for the APM, VMNG, and Global Commitment to Health demonstration remained unchanged for 2017, performance measures associated with additional non-fee-for-service payment models were identified. Prior to CMS submission, all payment model applications were reviewed to ensure that their associated measures were representative of the array of services provided and of the diversity of individuals served as well as aligned with the broader demonstration goals and objectives. This process was informed by the Results Based Accountability methodology. Results Based Accountability helps programs improve the lives of children, families, and communities and their performance because the framework:

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Commented [MMK6]: [redacted]

- Supports moving from talk to action quickly;
- is a simple, common sense process that is easily understood;
- helps groups to identify and challenge assumptions that can block innovation;
- builds collaboration and consensus; and
- uses data and transparency to ensure accountability for both the well-being of people and the performance of programs.

The AHS uses *Clear Impact Scorecards* to strengthen continuous improvement practices, including how they measure, monitor, and improve performance. Scorecards organize, present, and share data to tell a story. According to the *Results Based Accountability* methodology, each card has two parts: population accountability and program accountability. The former is accountability by a community for the well-being of a population and involves examining results for whole populations. The latter is accountability by the managers of a program for the performance of a particular program and involves examining results for the consumers or clients served by the specific program.

In addition to promoting population accountability through statewide trends in Scorecards, AHS uses Scorecards to demonstrate the performance of Departments responsible for implementing programs, services, and various activities – many of which support the Medicaid program. For example, AHS Departments currently use scorecards to enhance regular monitoring of their Global Commitment Investments. The AHS Performance Accountability Committee is examining the feasibility of using scorecards to enhance regular monitoring and reporting of Global Commitment evaluation and payment model performance measures. Monitoring performance measures in this manner allows AHS to gauge

success or failure against a performance target or baseline and ultimately engage in a data-driven decision-making process. In addition to maintaining a cohesive dashboard of data and information across Departments, this approach is also consistent with AHS's commitment to enhancing understanding and use of RBA within a broader system of accountability for all programs and services toward improved quality of service and outcomes.

APM AND DVHA – QUALITY, MEASURES, AND ACCOUNTABILITY

The APM Agreement included three broad population health measures: increasing access to primary care, reducing the growth in prevalence of chronic conditions (diabetes, hypertension, and chronic obstructive pulmonary disease), and reduce the number of deaths due to suicide and substance use disorder. More information on the specifics of those measures can be found in Appendix 1 of the APM Agreement. [cite] The GMCB, in collaboration with AHS, is responsible for monitoring the progress OneCare and the state are making towards achieving health outcomes and quality of care.

In the VMNG 2018 contracts, Attachment B, Section J lists the quality and outcome measures for which the OneCare is responsible. It also describes the Quality Incentive Pool Program, which aims to incentivize OneCare to ensure high quality care and good health outcomes under an all-inclusive population-based payment. [cite]

DAIL – QUALITY, MEASURES, AND ACCOUNTABILITY

Successfully shifting from fee-for-service to flexible payment models involves a key role of quality and performance measures to monitor whether appropriate care has been delivered. As DAIL and their community partners move toward reforming payment for LTSS in alignment with the ACO and under the APM Agreement, LTSS performance and quality measures need to be addressed. These measures provide the accountability to ensure that LTSS payments are linked with high quality, high value care. However, neither the APM Agreement nor the Vermont Medicaid Next Generation ACO model contract between DVHA and OneCare include LTSS measures that address the purpose and scope of LTSS. Therefore, as AHS works with the ACO and the GMCB to develop a plan for incorporating home- and community-based services and institutional services into the financial and quality targets of the APM Agreement, development of appropriate measures for these services is key.

The development of quality and performance measures for LTSS is ongoing, informed by both national developments and continued work under Global Commitment in Vermont. In 2016 and 2017, the NQF has made important progress on relevant measures. More information on this work can be found at:

- http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx
- https://www.qualityforum.org/Publications/2017/09/Medicaid_Innovation_Accelerator_Project_Final_Report.aspx

Additionally, 2017 saw the release of a CAHPS HCBS consumer survey module by CMS:

- https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

Based on this body of work, DAIL has begun compiling protential measures. These include but are not limited to:

Performance category	Performance Measure	Population	Source of Data	Frequency of Measurement
Eliminating Institutional Bias	Average number of people served per month by setting: nursing facility, home, licensed residential facility	CFC population	MMIS	Annual
Community Access	Proportion of people who do things they enjoy outside of their home when and with whom they want to	CFC, TBI, DDS Representative Samples	NCI-AD	Annual
Choice and Control	The proportion of people who make choices about their everyday lives (composite score regarding choice of daily schedule, how to spend money and free time activities)	DDS Representative Sample	NCI-DD	Annual
Choice and Control	Proportion of people who can choose or change what kind of services they get and determine how often and when they get them	TBI Representative Sample	NCI-AD	Annual
Employment	Proportion of people who have a paying job in the community, either full-time or part-time	CFC and TBI Representative Samples	NCI-AD	Annual
Employment	Proportion of people who would like a job (if not currently employed)	CFC, TBI, DDS Representative Samples	NCI-AD	Annual
Employment	Employment rate of people of working age receiving developmental disabilities services	DDS population of working age	State method	Annual
Employment	Employment rate of people of working age receiving TBI rehabilitation services	TBI population receiving rehabilitation	State method	Annual
Health Wellness	The proportion of people who describe their overall health as poor	CFC, TBI, DDS Representative Sample	NCI-AD	Annual

Other sources in Vermont to consider for relevant measures include:

- DA/SSA Master Grant performance measures
- DLP HHA survey results and CMS star ratings
- DLP NF survey results and star ratings
- Other NCI consumer survey results for CFC, DDS and TBI
- Critical incident reports

DMH – QUALITY, MEASURES, AND ACCOUNTABILITY

The children's mental health payment reform Quality and Value Component Workgroup is exploring what indicators will be used to evaluate program success and how providers will report on their performance. The group identified the following key qualities for selection of measures. The measures should-

- include population level outcomes
- increase the quality and value of the programs and services provided
- be feasible to collect
- provide meaningful data for continuous quality improvement efforts

The workgroup conducted a measurement inventory to identify measures from multiple sources, including Integrating Family Services, Centers for Excellence, and DMH master grant reporting requirements. Each measure was evaluated using the Medicaid Pathway Measure Selection Criteria[5] created in 2016. Measures were sorted into three categories based on how well they meet the criteria and how they fit with the APM Agreement and Results Based Accountability frameworks. Some measures have been eliminated from the list and those remaining continue to be refined to ensure that there is adequate variety in the measures to meet the principles identified for the model.

Next steps include identifying which of the selected measures to propose for value-based payments. Once the workgroup has finalized the recommended list of measures and proposed value-based payment measures, feedback will be solicited from the overarching Children's Change Workgroup and leadership. The finalized measures will be incorporated into the payment model.

Many of the performance measures and outcomes being considered for payment reform and the comprehensive quality strategy are reflected within DMH's Results Based Accountability scorecards. As payment reform progresses through the Quality/Value Component Work Group, the indicators and performance measures will change to align with these efforts.

In addition, over the past year, DMH has put considerable effort into creating a system of accountability for the Designated Agency Master Grant agreements. The Department has created a system to monitor performance measure submission and evaluation by Departmental program directors. Designated Agencies are expected to a unified set of performance measures for each program, as well as one performance measure that reflects what each mental health program at each Designated Agency uses to evaluate its own performance. The intent is to create a system that reinforces results based accountability from the top-down through state agency selected performance measures and outcomes and from the bottom-up through program selection of performance measures. The Department is also piloting the potential of using the RBA Clear Impact scorecard software as a tool for Designated Agencies to use to submit performance measure information to the Department, which will eliminate some administrative effort and delays in reporting between the Agency and the Department.

[5] The criteria were outlined *Medicaid Pathway Overview* report (p. 19): http://dvha.vermont.gov/global-commitment-to-health/medicaid-pathway-planning-overview-12.19.16-update.pdf

Finally, as part of the Agency of Human Services, the DMH uses the Results Based Accountability framework to evaluate the performance of our programs and initiatives.

Using several scorecards, DMH presents data and performance measures related to the department's programs and system of care. These outcomes include ensuring that all Vermonters are healthy. DMH also collaborates with many partners to reduce the suicide rate in Vermont and increase the availability of mental health treatment (both indicators).

The Department of Mental Health (DMH) Scorecard

- high level presentation of the Department's Programs and areas of focus
  https://app.resultsscorecard.com/Scorecard/Embed/9939

Reducing Seclusion and Restraint in Vermont's Psychiatric Hospitals

- data presented to the Emergency Involuntary Procedures (EIP) Workgroup and used by the Department to evaluate our initiative to reduce seclusion and restraint on inpatient psychiatric units
  http://app.resultsscorecard.com/Scorecard/Embed/10396

Vermont Psychiatric Care Hospital (VPCH) Outcomes

- Scorecard generated in response to legislative requirement to identify "desired outcomes, performance measures, and data requirements required to measure whether the hospital is achieving the stated outcomes for patient care, and the effectiveness of treatment services, patient monitoring, and safety requirements at the Vermont Psychiatric Care Hospital"
  http://app.clearimpact.com/Scorecard/Embed/8136

DMH System Snapshot

- Scorecard generated in response to 2012 Act 79, an act reforming the mental health system of care that details system measures on a quarterly basis
- http://app.resultsscorecard.com/Scorecard/Embed/14725

DMH Continued Reporting

- Scorecard generated in response to request for on-going quarterly measures that are presented in the annual Act 79 Report to the legislature
- http://app.resultsscorecard.com/Scorecard/Embed/14723

SECTION 5: CONCLUSION

The focus for 2017 was to stand up the VMNG ACO Pilot Program. It was also a year in which AHS worked closely with OneCare to prepare for 2018 and the expansion to Medicare and BCBSVT and the expansion in the number of hospitals, providers, and Vermonters participating in payment and delivery system reforms under the APM Agreement. It was also a year in which AHS looked closely at the work under its purview to evaluate equity in payments, accountability for the services rendered, and data the data and IT available. In some areas, the Agency was able to take significant steps forward, such as

increasing primary care reimbursement rates and establishing a clear decision-making process around IT. In other areas, work continues to evolve. Understanding where the gaps are in accountability is the first step before accountability can be improved and serve as keystone to payment reform. DVHA, DAIL, and DMH continue to make progress in this area.

As we look ahead to 2019 with the state's responsibilities under the APM Agreement in mind, the state will have to work closely with OneCare, the DAs, SSAs, and other community providers to build on 2017's progress and to identify services and providers that are prepared to undertake the changes necessary for successful payment and delivery reform.

APPENDICES

Timeline of required APM deliverables

Jenney Samuelson

Timeline of required APM deliverables

Commented [SJ7]: If you want more detail, I would recommend putting in the full table from the GMCB/AHS MOU

January 1, 2017

- Implement the **Medicaid Next Generation ACO** Program

June 30, 2020

- Develop a plan that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to **Community Health Services** is being used toward achieving the Statewide Health and Quality of Care Targets

December 31, 2020

- Develop a plan to coordinate the financing and delivery of Medicaid **Behavioral Health Services** with the All-Payer Model financial targets
- Develop a plan to coordinate the financing and delivery of Medicaid **Home and Community Based Services** with the All-Payer Model financial targets (December 31, 2020)

January 1, 2021 to December 30, 2022

- Add Medicaid Long-Term Institutional Services in All-payer Financial Target Services for Performance Year

Other? Final pre-print submissions for all non-FFS payment models to CMCS?

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SUBCOMMITTEE ON COMMODITY EXCHANGES, ENERGY, AND CREDIT

SUBCOMMITTEE ON NUTRITION

COMMITTEE ON THE BUDGET

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
VICE CHAIR, SUBCOMMITTEE ON RAILROADS, PIPELINES, AND HAZARDOUS MATERIALS

SUBCOMMITTEE ON ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT

SUBCOMMITTEE ON HIGHWAYS AND TRANSIT

Congress of the United States
House of Representatives

November 27, 2017

Honorable Seema Verma
Administrator
U.S. Centers for Medicare and Medicaid Services
200 Independence Avenue, Southwest
Washington, DC 20201

Dear Administrator Verma,

We are writing today in support of immediate changes to CMS' March 2014 "Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community." We are encouraged to hear that CMS is currently in the process of revising this guidance, and we hope that you will be able to provide us with a positive update in the very near term. We write today both to express our desire to see this guidance document changed, and to share our views on the value and importance of disability-specific congregate, farmstead, and lifesharing communities in the Medicaid program. As written, the guidance discriminates against these communities, as well as against other rural-based settings which offer individuals with disabilities an important choice as they consider the setting that best meets their individualized needs.

As you are aware, in January 2014 CMS issued a final rule on Home and Community-Based Services (HCBS) waivers. The intent of the rule was broadly supported, enshrining into regulation the importance of patient choice and dignity. Following publication of the final rule, in a March 2014 guidance document CMS took the position that disability-specific congregate and farmstead communities are more likely than other community-based settings to "isolate" individuals from the broader community and are therefore subject to a "heightened scrutiny" standard before CMS considers them to meet the home and community-based services standards. While we support protections which ensure that individuals receiving HCBS have full access to the benefits of community living, we believe the guidance document, as written, reflects a fundamental misunderstanding of how many disability-specific congregate, farmstead, and lifesharing communities operate.

We are particularly concerned that the guidance may have the unintended impact of discouraging and ultimately phasing out congregate and lifesharing models which promote individual independence, community integration, and enhanced quality of life for all served by these communities. These models, many of which are located in congregate and farmstead settings, are an important choice for Medicaid beneficiaries as they search for the particular setting that

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best fits their own individualized needs. In subjecting these communities to a heightened scrutiny standard, CMS has introduced significant uncertainty to the future of these communities.

By painting all congregate and farmstead communities with a broad brush, CMS threatens to remove a critical choice from individuals looking for a setting that provides individuals with a community that supports inclusion, not seclusion. We applaud CMS' intent in the 2014 final rule to protect patient choice and dignity, but urge CMS to revise its subsequent guidance to clarify that congregate and farmstead communities based on the lifesharing model are not subject to the heightened scrutiny standard. We understand that these communities would welcome third party certification (such as through the Center for Quality and Leadership) as an alternative to the current broad-brush policy.

Thank you for your time and consideration,

Sincerely,

John J. Faso
Member of Congress

Jacky Rosen
Member of Congress

Raja Krishnamoorthi
Member of Congress

cc: Brian Neale, Director, Center for Medicaid and CHIP Services
Tim Hill, Deputy Director, Center for Medicaid and CHIP Services
Michael Nardone, Director, Disabled and Elderly Health Programs Group
Ralph Lollar, Director, Division of Long Term Services and Supports
Melissa Harris, Senior Policy Advisor, Disabled and Elderly Health Programs Group

VERMONT

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Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
[phone] 802-241-0422
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Dear Ms. Kayala,

We are writing to invite your review of Vermont's current processes and standards for service authorization and person-centered planning in the Choices for Care program. We also invite your feedback on how to best achieve alignment between differing federal and state standards as Vermont plans for greater integration with Patient Centered Medical Homes, Specialized Health Homes and Accountable Care Organizations for Choices for Care. Attached please find a summary brief outlining our current program operations, current and proposed planning efforts and timeline.

We understand that federal conflict of interest rules established for 1915 (c) and other similar home and community based service (HCBS) programs limit the ability of a single provider to offer both case management and direct services. Vermont shares the goal of ensuring participant access to effective, high quality, conflict free case management. However, we are concerned that implementation could limit participants' rights to choose their providers, inhibit participants' ability to access necessary care, and disrupt our current efforts at integrating primary care with our managed long term services and supports (MLTSS) including HCBS values and principles.

Vermont seeks CMS assistance in developing a policy strategy that aligns HCBS requirements with Choices for Care policies and operations in order to achieve the following objectives:

- Maintain Vermont's commitment to individual consumer choice and control as a foundational concept of the successful Choices for Care program
- Strengthen necessary protections to ensure that care planning activities are not influenced by a providers' other service delivery roles
- Maintain and improve access to person-centered planning statewide
- Support ongoing quality improvement in care delivery
- Sustain Vermont's rural service delivery system
- Maximize use of public resources for care delivery through administrative efficiencies and minimize budget shortfalls
- Align with Vermont's integration of LTSS with primary care, preventive care, mental health care, and substance use treatment in Vermont health reform efforts, including efforts to achieve greater consistency across public and private payers.

Vermont seeks to work with CMS to align these objectives and mitigate any unintended consequences in addressing conflicts of interest, including:

- Restriction of individual participant choice
- Erosion of access to care due to:
    - Loss of comprehensive providers and specialized expertise

  - Diminished availability of services resulting from providers discontinuing either case management or direct care services
  - Disruption of case management services including slower access to HCBS and poorer quality of case management services due to the limited availability of qualified case management staff, during any transition period
- Diversion of funds away from direct services to support a new administrative structure for the provision of case management-only services.
- Increased program costs resulting from different yet overlapping service definitions for case management, care coordination, service coordination and authorization, medical social work and person-centered planning across multiple programs and settings

We seek your concurrence on our proposed planning process and timeline. The process is designed to allow for meaningful stakeholder input into a delivery system transformation that promotes the integration of primary care with our MLTSS and consistency in regulatory policies across public and private payers.

We are optimistic that Vermont and CMS can partner to develop a solution that continues to promote individual consumer choice and control, ensures that services are accessible and sustainable, promotes effective and cost-efficient integrated service delivery, and provides appropriate safeguards against conflicts of interest.

We look forward to a discussion following your review of the attached materials. Please don't hesitate to contact either of us (Selina Hickman at 802-585-9934 or Commissioner Hutt at 802-241-0360) for additional information and/or questions.

Sincerely,

Selina Hickman,
Director of Healthcare Operations, Compliance and Improvement
Agency of Human Services, Secretary's Office

Monica Hutt,
Commissioner, Department of Disabilities, Aging and Independent Living
Agency of Human Services

Cc: Megan Tierney-Ward, Director Adult Services Division
Sara Lane, Director Choices for Care Program
Steven Costantino, Medicaid Director
Dina Payne, CMCS State Demonstrations, VT 1115 Project Officer

Encl: Choices for Care Program Summary and HCBS/Medicaid Planning Timeline

Choices for Care Program Summary and Proposed Planning to Strengthen Conflict of Interest Protections: July 2016

This document provides a summary of the Choices for Care program under Vermont's Section 1115 public managed care demonstration, Global Commitment to Health. Section I provides an overview of the Choices for Care program including participants, providers, case examples and outcomes. Section II provides an overview of Vermont's proposed planning process and goals in establishing greater integration between primary care, mental health and managed long term services and supports (MLTSS) across public and private payers. Section III provides an overview of our planning timelines and specific action steps.

I. Choices for Care Program Overview

Program and Participants

In 2005 Vermont opted not to continue several former 1915 (c) waivers for persons with physical disabilities and frail elders, but rather to seek Section 1115 approval to implement a larger reform based on equalizing the entitlement and creating a seamless system of care between nursing facility and an array of cost effective community based care options. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full consumer choice in when, where and from whom to receive services.

Persons who meet skilled nursing facility level of care (known as Highest and High Needs Groups) are eligible to receive an array of services within the CFC benefit package. CFC also includes a limited benefit package for Medicaid State Plan and non-Medicaid participants who do not meet, but may be at risk of, skilled nursing facility placement; this is known as the Moderate Needs Group. The Choices for Care program is managed by the Department of Disabilities, Aging and Independent Living (DAIL) as part of Vermont's Public Managed Care model and as designated by the Agency of Human Services (AHS).

Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules that are in the High or Highest Needs Group (i.e., meeting nursing facility level of care). As of January 2016, 1,826 persons in the Highest and High Needs Group chose skilled nursing facility care, 1,605 persons chose home based supports, and 487 persons chose community residential care (PNMI). As of January 2016, 1,492 persons received limited in home benefits as part of the Moderate Needs Group. The median age of CFC participants is 83 and the median length of stay in the program is 1.6 years, with most program terminations due to death of the recipient.

Providers, Case Management Certifications and Protections

Vermont is a small rural state. The State maintains a geographically designated Home Health Agency (HHA) system. Twelve HHAs are recognized in State law/regulation and are required to

serve Choices for Care program participants in their region. One agency is recognized for statewide delivery of services.

In addition, through the Older Americans Act (OAA), DAIL designates five regionally based Area Agencies on Aging responsible for statewide coverage of OAA services. These AAA organizations are also authorized to provide HCBS companion services under CFC. Vermont has received federal approval under the Older Americans Act State Plan to allow AAAs to provide both case management and direct care when needed to assure access to necessary services for participants.

The full array of CFC services is delivered through the following providers:

- 75 Assisted Living Residences and Residential Care Homes (PNMI)
- 37 Skilled Nursing Facilities
- 12 geographically designated, non-profit HHAs
- 1 statewide, for-profit HHA
- 5 Area Agencies on Aging
- 14 Adult Day Providers
- 15 Specialized non-profit agencies with Developmental Disability, Traumatic Brain Injury and Mental Health expertise in creating highly individualized Adult Family Care placements for persons with complex needs in the community
- 1 Administrative Services Organization for persons who self-manage services

Given the rural nature of the State and its small size, no Vermont provider only offers case management services. Due to Vermont's labor market, small population and economic drivers, developing additional provider types has not been economically viable or supported by legislative action. It is not unusual to have multiple community agencies involved with any given CFC participant.

> *Ray lives in his family home; his LTSS supports through the Choices for Care program have included 8 months of Skilled Nursing Facility Care. He currently lives in his family home with his wife. Tom receives 40 hours a week of caregiver support through a combination of his daughter's support (unpaid) and caregivers from the Home Health Agency. He also receives companion services through the Area Agency on Aging. His case management choice is the Home Health Agency. Additional supports have been provided through volunteer time from other family and friends. Home modifications for wheelchair access have been supported through the Veterans Administration and volunteer labor. Medical follow-up is provided through his primary care physician in the community.*

The Vermont Department of Disabilities Aging and Independent Living (DAIL) conducts periodic on-site quality reviews and certifications of providers designated to provide case management services in the CFC program. Both HHAs and AAAs undergo certification. In the event that a consumer chooses a case manager who is also affiliated with the provision of one or more services in their care plan, Vermont standards and policies require that providers must have policies in place to address conflict of interest; individual treatment team conflicts must be

considered and mitigated. In several regions, HHAs have chosen to create separate entities with differing supervisory structures to preserve a distinction between case management and direct care staff. Vermont standards are currently under review as part of our HCBS Quality Strategy and will be enhanced based on stakeholder input. A link to our current standards is available at Case Management Standards.

All Choices for Care participants have access to the State Long-Term Care Ombudsman to help resolve provider complaints, regardless of whether they receive their services in a facility or home and community setting. In addition, the State maintains a grievance and appeal system and supports Aging and Disability Resource Centers (ADRCs) in each region.

Services and Person-Centered Planning

All individuals applying for Highest and High needs services meet with a State of Vermont Long Term Care Clinical Coordinator (LTCCC) Nurse for an initial assessment of clinical eligibility and physical functional needs. State staff also are responsible for the authorization of any subsequent change of service once enrolled. Initial meetings include a discussion of service options, providers and a referral for independent options counseling as needed. Consumers have equal access to an array of traditional State Plan services, including skilled nursing facilities, residential care in a PNMI (private non-medical institution) facility, in home and community based options such as companion care, respite and other rehabilitative therapies as well as flexible options for self-managing some or all of their care providers. Once enrolled in the CFC program, a consumer may choose whether to receive on-going case management services from a HHA or an AAA. Thus final CFC service packages are based on clinical profile, support needs, State Plan and unique section 1115 demonstration authorities and services.

Julie was diagnosed with spinal stenosis years ago. As time passed, it became increasingly debilitating, her in home support needs increased and she lost use of her arms. Following surgery and 5 months of nursing facility services she began to regain limited use. Julie is 86 and now lives in her own family home; she currently has a combination of surrogate/self-managed in home support workers and Home Health Agency Case Management.

The LTCCC's are also responsible for utilization review of any request for home based, Adult Family Care and Enhanced Residential Care services and anytime there is an initial assessment reassessment or a change in significant function prior to the annual reassessment date.

Unlike traditional 1915 (c) programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, acute rehabilitation facilities, home care and adult family care in any given eligibility period. All participants meet skilled nursing facility level of care and have complex medical profiles, support needs and/or dementia care needs. As such, there is a mix of providers involved in any given service plan. Hospice and end of life care at home are not unusual in the program and services may change rapidly over the course of several months.

Roger is diabetic with multiple complications of this disease including proliferative diabetic retinopathy of both eyes and renal failure. He undergoes hemodialysis three times a week, Roger's Choices for Care services have included nursing facility care, hospitalization for cardiac care and he is

currently in an Adult Family Care placement in the community. While hospitalized, he developed Ascites, and requires a periodic paracentesis procedure. His needs must be carefully monitored as they can change rapidly. Roger also has multiple other complex medical conditions and his diet and nutritional needs are closely monitored by his home provider. Roger also loves living in the country, going for rides in the woods and fishing.

Roger is closely followed by his primary care physician. He is living in an Adult Family Care setting with an independent home provider and hosted through a local agency with specialized expertise in creating and monitoring individualized living arrangements. The host agency provides case management support, the independent home provider offers 24/7 care services. All involved agencies, the home provider and support services were chosen and approved by Roger and his legal guardian.

Outcomes

Prior to the implementation of the CFC Demonstration, 241 persons were on the waiting list for 1915 (c) services. During start up in 2005, all persons were moved from the waiting list. Waiting list counts peaked at 100 persons in 2006 and fluctuated between no waiting list and 80 persons during the recession. Since March of 2011, Vermont has operated the program with no individuals on the waiting list.

The CFC program routinely collects and reviews consumer feedback on experience of care and satisfaction. Periodic consumer surveys show that our consumer's perception of HHA case manager performance equals or exceeds that of AAA case managers, results also yield high levels of satisfaction with questions specific to choice and control in the home and community services, including choice of case management agency. In all case management areas, persons in the Highest and High needs group reported significantly higher ratings than those in the Moderate needs group who receive a more limited benefit package. A summary of several questions related to choice, control and case management across all participants, (High, Highest and Moderate needs) is provided in Table 1 below. A link to full survey results is here: CFC 2015 Consumer Survey.

Table 1: Choices for Care, Consumer Experience of Care Survey Highlights All Groups

Consumer Survey Question	2015 Results
How would you rate the amount of choice and control you had when you planned the services or care you would receive? (% excellent or good)	85%
How would you rate how well people listen to your needs and preferences? (% excellent or good)	90%
I get the services I need the way I want to get them. (% agree or strongly agree)	90%
My current residence is the setting in which I choose to receive services. (% agree or strongly agree)	97%
My services help me to achieve my personal goals. (% agree or strongly agree)	90%
How satisfied are you with your case manager? (% very or somewhat satisfied)	93%
I feel I have a part in planning my care with my case manager. (% always or almost always)	85%
My case manager helps me understand the different service options that are available. (% always or almost always)	84%
My case manager coordinates my services to meet my needs. (% always or almost always)	86%

In addition to direct consumer feedback, the State has advanced a number of independent program evaluations from the University of Massachusetts Medical School that describe general program performance measures and quality outcomes. These can be viewed at the following link: UMASS Evaluations, Consumer Choice and Control.

Offering participants full choice based on clinical need has been successful in shifting the balance from skilled nursing facility to community care. In all but three regions the balance is 50/50 with several regions lowering skilled nursing facility care even further. As more participants who require skilled nursing services 24/7 opt to stay at home, the medical complexity of in home care has been increasing. At the same time Vermont has seen a gradual increase in consumers in home and community care options choosing HHAs as their care manager, from approximately 40% in 2010 to 52% in 2016. Vermont is second highest after California relative to the percent of persons who self or surrogate manage their care giver services; over 50% of all Personal Care Services in CFC are self or surrogate managed.

CFC data reports can be viewed at: DAIL CFC Data Reports.

Section II Standards and Options for Alignment

Federal and State Standards (1915 (c), Older Americans Act, State Designation Regulations)

The State of Vermont understands that consumer choice, coupled with beneficiary protections (e.g., options counseling and provider requirements to address potential conflict of interest) under the Choices for Care Program may not be adequate to address the requirement in 42 CFR 441.301 (c)(1)-(3) that states:

> *Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process*

Vermont law assigns a geographic area to each of the twelve HHAs. Given the unique nature of Vermont's delivery system, the small size of the State and the importance of consumer choice as a fundamental tenet of the CFC program, Vermont has also historically requested federal approval under the Older Americans Act State Plan to allow Area Agencies on Aging to provide both case management and direct services to assure access to necessary services.

In addition, Vermont has just begun a provider and stakeholder planning process to promote a model of care based on full integration of service delivery such as those employed in Patient Centered Medical Homes, Specialized Health Homes and Accountable Care Organizations.

We are requesting your determination as to whether the current program operations meet CMS criteria for the "geographic exception" process contemplated in the HCBS regulation while the State plans for its next steps in delivery system transformation and quality improvement.

Proposed Action Plan

Vermont has been engaged in a multi-pronged effort to promote the full integration of primary care, mental health and MLTSS delivery networks in support of a comprehensive and seamless person centered model of care. Vermont has had success with integrated care approaches that connect providers across the care continuum of services and will be discussing MLTSS integration options relative to:

- Enhancing current Patient Centered Medical Homes and Services and Supports at Home (Blueprint for Health and SASH);
- Creation of a Specialized Health Homes; and/or
- Alignment of MLTSS with a Medicaid Accountable Care Organization (ACO) for consistency across public and private payers.

On June 7, 2016 a stakeholder planning group comprised of advocates, consumers, providers, primary care and other stakeholders came together to advance planning for a fully integrated model of care. HCBS standards will be an important element of all planning. Based on our immediate next steps and 2016 planning already underway, Vermont intends to continue stakeholder engagement in intensive planning process. Any change in the delivery system for Choices for Care that the State might contemplate will require further discussion with our advisory boards, stakeholder engagement and public comment prior to the State making a commitment on final direction.

Options that contemplate new State staff, new entities or that change the statutory role of HHAs in Vermont will require approval through the State's legislative process during the January – May of 2017 Legislative session. In addition, any action during the 2017 session may trigger changes in rules and regulations that could take another three to twelve months to fully implement. Thus, operational changes would not be expected earlier than October 1, 2017 and more feasibly July 1, 2018. This timeline will also need to coordinate any changes in AAA designation and services with the submission of our next Older Americans Act State Plan in September of 2018.

The State's proposed planning activities are summarized below and outlined in more detail with expected timelines in Section III.

1. **Request a determination from CMS for an HCBS exception or other policy solution** based on: the State's current Section 1115 demonstration model; a determination that the HHAs and AAAs, who provide both direct care and case management services, are the only qualified entities for the persons they serve.
    a. Vermont could provide CMS additional detail regarding the HHA and AAA structure and regional designations if this would be helpful.

b. Vermont could also encourage current providers to separate lines of business for case management services by creating different corporate entities if CMS determines this to be a required step for the current CFC system.

2. **Enhance Choices for Care program standards,** including clarification and monitoring of acceptable conflict of interest protections and separation of functions within provider agencies for staff supervision and decision-making for the provision of direct services and case management. This work will be accomplished as part of our comprehensive quality improvement plan and HCBS alignment work already in process with completion expected December 2016.

3. **Engage Broad Based Planning,** using the timeline and action steps in Section III engage stakeholders in a meaningful assessment of delivery system needs and options for improvement, including how to best align services and supports in light of HCBS rules, medical complexity of Choices for Care participants and desired health care reform goals across public and private payers.

4. **Options for HCBS alignment to be considered during 2016 planning** (see Section III steps) include but are not limited to:

    a. **Maintain Choice and Support Primary Care Integration**: Adoption of interdisciplinary/agency teams similar to Specialized Health Homes to Integrate LTSS/CFC and physical health care. Initial considerations are outlined below.

        - Aligns with Health Home, ACO and/or Patient Centered Medical Home models
        - May not meet CMS HCBS standards
        - May require additional Section 1115 demonstration waiver for HCBS standards to achieve desired integration with primacy care and/or Medicaid ACO models
        - May require adjustments to the State's Older Americans Act State Plan in 2018
        - Would allow for beneficiary choice
        - May still require CMS determination that integrated care team meets the "geographical exception" standard as contemplated in HCBS rule

    b. **Create New Entity**: Create a new type of care management entity. This could include a separate case management provider for regional or statewide service provision. Would require new legislative appropriation and potential changes to CFC regulations and program rules. Initial considerations are outlined below.

        - Could add additional administrative infrastructure and divert resources away from direct care
        - Would meet CMS HCBS standards
        - May not align with Health Home model and standards
        - Will not offer beneficiary choice
        - Could fragment services if provider is not fully integrated into existing care teams

c. **Increase State Staff and Enhance Role**: Adopt a State run model for care management. This would involve an increase in State staff positions to deliver case management services. Initial considerations are outlined below.

   - Would require legislative approval
   - Provides safeguards for consumer and ensures non-duplication of services
   - May result in additional infrastructure and could divert resources away from direct care
   - Would meet CMS HCBS standards
   - Will not offer beneficiary choice in case management provider
   - May not be feasible or approved by legislature given current budget shortfalls
   - Potentially inconsistent with the direction of current health reform care and provider led integration efforts

d. **Designate a Single Provider Per Region**: Designate a single provider per region and request CMS exception as contemplated in Federal HCBS rules. Initial considerations are outlined below.

   - AAAs and HHAs each offer different expertise that is important to CFC participants.
   - May result in destabilization of providers not designated as single entity
   - Would eliminate consumer choice

Vermont seeks CMS collaboration on how to best achieve alignment between differing federal and state standards as Vermont plans for greater integration with Patient Centered Medical Homes, Specialized Health Homes and Accountable Care Organizations for the Choices for Care program. Vermont shares the goal of ensuring participant access to effective, high quality case management and feels that beneficiary choice should remain the overarching tenant of the Choices for Care Section 1115 Demonstration program.Vermont seeks CMS assistance in developing a policy strategy that aligns these objectives. Our proposed planning process and timeline to address these and other integration issues is outlined in Section III.

Section III Action Plan and Timeline

Outlined below and on the following pages is Vermont's 2016 -2017 action plan for: assessing options and innovations in integrating care for Medicaid enrollees across physical health, mental health and long term services and supports; and reviewing those options for alignment with State and federal rules and emerging innovations under the Global Commitment to Health Section 1115 Demonstration.

Vermont Medicaid Pathway/HCBS Action Steps 2016	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1. Establish membership and work group meeting schedule, host June kick-off session.								
2. Collaborate with CMS to identify policy and operational alignments relative to HCBS and Specialized Health Home and ACO models.								
3. Identify delivery system transformation goals: solicit state staff, provider, stakeholder, and consumer/advocate concerns with current delivery model, program requirements (including alignment with planned updates to HCBS standards) and payment methodologies.								
4. Preliminary review of draft scope to determine if program or legal requirements present any known limitations or impediments to reform initiatives.								
5. Review final draft scope and discuss delivery system design models to support VT integrated model of care, including alignment with HCBS, health home, OAA and other federal.								
6. Review results of HCBS provider self-assessments and address implications in planning.								
7. Identify delivery system design elements that specifically support an integrated delivery system, including alignment with VT Blueprint for Health and planned HCBS rule updates and discussion of how to address delivery system changes to eliminate conflict of interest issues and support meaningful beneficiary choice in person-centered planning.								
8. Review other states' models and opportunities to enhance funding (e.g., Medical Home and/or ACO investments in community based care) as applicable. Models may include, but not be limited to: specialized health home models; new case management entities for person- centered planning; increased State staff for case management and person-centered planning; designation of one provider per region to provide case management services; other innovative models that may support the State's goals of								

HCBS CQS July 2018 000406

Vermont Medicaid Pathway/HCBS Action Steps 2016	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
maintaining enrollee choice and comprehensive interdisciplinary teams.								
9. Identify alternatives to current payment models that support the VT integrated model of care and the proposed delivery system design model.								
10. Identify Quality and Oversight Framework including any new performance and outcome measures and alignment with planned HCBS updates.								
11. Present preferred design options for delivery system and payment reform, ensuring one drives the other. Solicit input from providers, stakeholders and consumer/advocates. To include outreach to providers not on planning team and formal and informal stakeholder feedback sessions.								
12. Identify standards that may require updating to strengthen beneficiary protections and mitigate conflict of interest								
13. Determine Resources and/or Technical Assistance needed to implement preferred delivery system and payment reform models for both short and long-term sustainability (e.g. data, staffing, change in standards or certification processes).								
14. Identify which features of the proposed reforms, if any, would require approval from CMS.								
15. Define approach (e.g., SPA, GC Demonstration amendment, GC technical review or appendix change) and timeline for any necessary CMS review.								
16. Identify any Statute, regulatory, policy or budgetary changes needed.								
17. Determine provider readiness for reforms and identify any final obstacles.								
18. Develop a proposed 2017 implementation date and multi-year plan for operational changes to support reform model, align with HCBS and other State and Federal standards & solicit feedback.								
19. Coordinate a timeline for any necessary changes between the OAA State Plan and CFC Demonstration.								
20. Seek approval from CMS and/or Legislature as needed								
21. Finalize implementation dates of operational changes.								

HCBS CQS July 2018 000407

Vermont Response to CMS Inquiry
June 23, 2017

CMS Requests from 05/04/16

I'm following up on this memo from last summer regarding the geographically designated HHAs that CMS is reviewing. We're wondering about item 1a on page 6. Could you elaborate on the statement regarding a potential determination that the HHAs/AAAs are the only qualified entities to provide both direct care and case management services. Specifically, does VT believe that to be the case statewide or only in certain geographic entities? Any further information that could help us consider a potential designation would be helpful.

Vermont Response:

The answer to your question is Yes- HHAs/AAAs are the only qualified entities to provide both direct care and case management services statewide. HHAs are designated in Vermont state statute and AAAs are designated by the State and are established in accordance with the Older Americans Act. When providing case management, both entities must follow the same Case Management Standards and Certification Procedures for Older Americans Act and Choices for Care. This unique arrangement results in the only willing and qualified entity to perform assessments of functional need and develop person-centered service plans also providing HCBS.

Hutt, Monica

From:	George, Camille
Sent:	Tuesday, June 19, 2018 2:00 PM
To:	Hutt, Monica
Subject:	FW: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission
Attachments:	RE: Follow up question on CFC HHA/AAAs; RE: Vermont Choices for Care Program Summary and Proposed Planning to Strengthen Conflict of Interest Protections; Conflic Free Case Management_DA_DMH(03).docx

See highlighted below, could be a problem. I will speak with Clarence before sending anything out and also about the issue highlighted below. I was clear in a message to him that one question is what information is public and how to share it.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
Cell Phone: 802.798-2079
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

ALZHEIMER'S & BRAIN awareness month
alzheimer's association

June is Alzheimer's and Brain Awareness Month! Over 13,000 Vermonters are living with Alzheimer's Disease, but growing evidence indicates that people can reduce their risk of cognitive decline by adopting key lifestyle habits. Learn the 10 Ways to Love Your Brain. If you are concerned about a loved one or yourself, ask your health care provider to perform a brief cognitive assessment. Early screening gives more time for families to plan next steps and access helpful resources and supports. Cognitive screening is included in Medicare's annual Wellness Visit and Medicare also offers a new benefit for dementia planning support. For questions, local resources and support, contact the Alzheimer's Association Vermont Chapter at 1-800-272-3900.

From: Hickman, Selina
Sent: Tuesday, June 19, 2018 1:34 PM

To: George, Camille <Camille.George@vermont.gov>; Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Davis, Clarence <Clarence.Davis@vermont.gov>
Subject: RE: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission

Hi Camille,

You have the major communications sent to CMS. I've attached two emails and another document that could be helpful:

- Re: Vermont Choices for Care Program Summary and Proposed Panning to Strengthen Conflict of Interest Protections: this email shows multiple attempts to gain response from CMS on the CFC conflict of interest exception request. It also highlights what we and they understand; the exception criteria is not a perfect fit for Vermont's situation, as there is more than one available case management agency.
- Re: Follow up question on CFC HHA/AAAs: this email shows CMS confirmation that our follow up response was received.
- Conflict Free Case Management_DA_DMH(03): this document was sent to CMS on 9/22/17 and seeks the conflict free case management exception for mental health programs and services provided through Designated Agencies. This brief is able to show clearly that there is only one willing and qualified case manager for Mental Health HCBS services. No response has been received to this brief.

Finally, CMS indicated to the State of Vermont in conversations that any exception to the conflict free case management requirements described in federal regulations must be enacted through an amendment to our 1115 waiver. At the time, we decided the next opportunity to ask for the exception would be through the SUD amendment process, however, I do not believe that loose end was tied off prior to the SUD amendment approval.

Let me know if there is anything else I can assist with.

VERMONT | Selina Hickman
Director of Policy
Department of Mental Health

From: George, Camille
Sent: Tuesday, June 19, 2018 11:49 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Davis, Clarence <Clarence.Davis@vermont.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: FW: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission

Thanks for sending this information along, Shawn. Clarence, I'd like to touch base with you about this. At last week's DAIL Advisory Board meeting, Shawn and a couple DAIL staff provided an update on the progress being made in implementing the CMS Home- and Community-Based Services Rules. In the course of the update, the topic of conflict-free case management came up and some present requested to receive a copy of the conflict free case management waiver exemption that the state filed with CMS and related documentation. This is a pretty sensitive topic, with strong opinions on both sides. Before we send anything out to the DAIL Advisory Board (and in fact, it was 2 staff from the DD Council who are not members of the DAIL Advisory Board, but were in attendance) I'd like to consult and make sure we are on the same page about what we send out. I've cc'd Selina as I know she was very involved in this process and the exemption request and may both be aware of additional documentation and have some helpful advice.

Do you have time to touch base about this within the next week or so?

Also, Shawn, if you can send me the link to the DVHA webpage that contains the additional information about the Comprehensive Quality Strategy and other information related to the HCBS rules, I can include that once we sort out what additional information will be shared.

Thanks.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
Cell Phone: 802.798-2079
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

June is Alzheimer's and Brain Awareness Month! Over 13,000 Vermonters are living with Alzheimer's Disease, but growing evidence indicates that people can reduce their risk of cognitive decline by adopting key lifestyle habits. Learn the 10 Ways to Love Your Brain. If you are concerned about a loved one or yourself, ask your health care provider to perform a brief cognitive assessment. Early screening gives more time for families to plan next steps and access helpful resources and supports. Cognitive screening is included in Medicare's annual Wellness Visit and Medicare also offers a new benefit for dementia planning support. For questions, local resources and support, contact the Alzheimer's Association Vermont Chapter at 1-800-272-3900.

From: Skaflestad, Shawn
Sent: Tuesday, June 19, 2018 10:47 AM
To: George, Camille <Camille.George@vermont.gov>
Cc: Davis, Clarence <Clarence.Davis@vermont.gov>
Subject: FW: Vermont 2018 Inter-Governmental Agreement and Rate Certification submission

Hi Camille – as per your request after last week's DAIL Advisory Board Meeting – attached are the following conflict-free case management items:

- Geographic exception request application (pdf: CFC Brief Action Plan – pp. 5 and 6)
- CMS correspondences (Outlook item: Follow Up question on CFC + embedded pdf: Vermont response)

I have copied Clarence because this item as discussed with him and Martha back in April – and I am not sure if any action has been taken since that meeting. Please let me know if you have any questions re: the attached documents.

Best,

Shawn

Conflict-Free Case Management and Vermont Community Mental Health Services

This policy brief seeks to illustrate how the conflict-free case management exception found at 42 CFR § 441.301 may be applied to the State of Vermont Community Mental Health system through examination of Vermont's 1115 Demonstration, State statutes and Administrative rules. Specifically, this brief seeks to demonstrate that "[...]the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS."

1. Global Commitment to Health 1115 Demonstration Waiver

Through its Demonstration, Vermont employs a managed care-like delivery system in which a unit of state government operates largely as if it were a non-risk prepaid inpatient health plan. One component of the managed care-like delivery system is establishing a network of providers that is adequate to meet the needs of individuals served. This construct is reflected in the section 1902(a)(23)(A) "freedom of choice" waiver authority provided through the Demonstration and further detailed at STC 27 "Limitation of Freedom of Choice." This authority permits the State to use specialized provider networks for special health programs including CRT and SED (also known as Enhanced Family Treatment (EFT)). Individuals that are eligible for Medicaid, but who do not meet eligibility criteria for CRT and SED, and who require medically necessary mental health services under the Medicaid State Plan may seek such care from any qualified provider enrolled in the Vermont Medicaid program and is not restricted to the specialized provider network for the special health programs.

2. Vermont Statutes

Vermont State statute at 18 V.S.A. § 8907 "Designation of agencies to provide mental health and developmental disability services" further establishes and requires designation of specific agencies as providers of community mental health services. Specifically, the statute requires:

> "(a) Except as otherwise provided in this chapter, the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living shall, within the limits of funds designated by the Legislature for this purpose, ensure that community services to persons with a mental condition or psychiatric disability and persons with a developmental disability throughout the State are provided through designated community mental health agencies. The Commissioners shall designate public or private nonprofit agencies to provide or arrange for the provision of these services."

The statute further establishes that the designated agencies must provide or otherwise arrange for all required services within their jurisdiction and for individuals who "reside within the geographic area served by the agency."

Vermont State statute at 18 V.S.A. § 8912 establishes the only instance in which services may be provided by non-Designated Agencies (also known as "Specialized Service Agencies"). This may occur in the instance that services "[...] are not available from designated community mental health agencies."

3. Administrative Rules

Agency Administrative rules on Agency Designation echo and further clarify the Vermont State statutes. Rules at section 2 establish that the Commissioner "[...] shall designate one agency in each geographic area of the state to assure that people in local communities receive services and supports, consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, regulations promulgated by DDMHS, the goals of Vermont for its citizens, the goals of the citizens themselves, and other policies, plans, regulations, and laws."

Minimum qualifications for these providers are established at section 4 of the same rules.

Section 5 describes the conditions under which a Specialized Service Agency may be established and reiterates that "The Commissioner may enter into a new Specialized Services contract only if the Commissioner determines that these services are not available from or cannot be developed by a Designated Agency within a reasonable timeframe and in the manner required by the department."

Discussion

As a result of the above policy environment, Vermont's Community Mental Health System of Care is currently comprised of ten (10) Designated Agencies operating in distinct geographic regions of the state and two (2) Specialized Services Agencies. These Designated and Specialized Service Agencies, as authorized by federal and state authorities, are the only qualified and willing providers of case management services for individuals they serve through the HCBS-like CRT and EFT programs.

The Vermont statutes have driven the comprehensive service capacities of the existing provider network and current system efficiencies. In addition to the citations above, Vermont has embedded significant protections and safeguards for individuals and families served, as follows:

- ✓ In 2001, Administrative Rules for Agency Designation were promulgated in Vermont requiring consumer and family majority representation in modifications to service delivery programs and transparency in system oversight at both a regional level, as well as, state level for SPMI adults, SED children and their families, and the developmentally disabled.

- ✓ At the onset of its 1115B waiver authority for SPMI adults in 1999, a grievance and appeals processes was put in place in consideration of the limitation of Freedom of Choice and continues through the most recent renewal STC 27 to assure ongoing protections and safeguards for individuals served by the Designated Agency system.

- ✓ These same grievance and appeals safeguards are also codified in the Administrative Rules for SED children and families and developmentally disabled individuals served.

- ✓ Vermont also has strong advocacy networks operating statewide that are supported by state resources in their mission to assist the population groups most frequently served by the Designated Agency Network. These organizations are knowledgeable advocates and represent individual consumers and their collective voices when access or unmet service

needs are identified and should be addressed through flexibilities of the State's 1115 waiver and requirements outlined in Administrative Rules.

Vermont believes that its existing system infrastructure meets the intent and affords the safeguards conceptualized by organizationally separating case management service from organizations providing other, and often multiple types of, needed services to vulnerable populations. As a small rural state and with mechanisms currently in place, the creation and support of additional organizations of specialized service capacity would not be cost effective in administration or necessarily efficient for the individual or families receiving services. Vermont believes that it can demonstrate through its inclusion of persons served and multiple existing safeguards, oversight activities, and feedback and reporting mechanisms that it meets the spirit and intent of the HCBS Rule for conflict free case management.

Hutt, Monica

From: Hickman, Selina
Sent: Friday, June 23, 2017 11:36 AM
To: Schenck, Tom M.(CMS/CMCHO); Skaflestad, Shawn
Cc: Hutt, Monica
Subject: RE: Follow up question on CFC HHA/AAAs

Great- thank you, Tom!

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
(802) 585-9934

From: Schenck, Tom M.(CMS/CMCHO) [mailto:Tom.Schenck@cms.hhs.gov]
Sent: Friday, June 23, 2017 11:34 AM
To: Hickman, Selina <Selina.Hickman@vermont.gov>; Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Thanks, Selina! Glad to have you back! I've passed this along to our HCBS SMEs and I'll be in touch once I know next steps.

From: Hickman, Selina [mailto:Selina.Hickman@vermont.gov]
Sent: Friday, June 23, 2017 10:58 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Schenck, Tom M.(CMS/CMCHO) <Tom.Schenck@cms.hhs.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Hi Tom,
I am back from leave and following up on your below inquiry from 5/4. Please see attached for Vermont's response and let me know if there is additional follow up needed.
I hope you are well!

Best,

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
(802) 585-9934

From: Skaflestad, Shawn
Sent: Friday, May 05, 2017 10:48 AM
To: Schenck, Tom M.(CMS/CMCHO) <Tom.Schenck@cms.hhs.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Tom – thanks for the follow up question. I will confer with the appropriate folks here at the agency and be back in touch.

Best,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
Agency of Human Services
280 State Drive Center Building
3rd Floor – E310-1
Waterbury, VT 05671-1000
Office: (802) 241-0961
Cell Phone: (802) 585-4410
Fax: 802-241-0450

Find out how Vermonters are doing with the AHS Results Scorecard.
(Access through Internet Explorer 10, Firefox, or Google Chrome).

From: Schenck, Tom M.(CMS/CMCHO) [mailto:Tom.Schenck@cms.hhs.gov]
Sent: Thursday, May 04, 2017 5:32 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: Follow up question on CFC HHA/AAAs

Hi Shawn,

I'm following up on this memo from last summer regarding the geographically designated HHAs that CMS is reviewing. We're wondering about item 1a on page 6. Could you elaborate on the statement regarding a potential determination that the HHAs/AAAs are the only qualified entities to provide both direct care and case management services. Specifically, does VT believe that to be the case statewide or only in certain geographic entities? Any further information that could help us consider a potential designation would be helpful.

Thanks,

Tom Schenck
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
(617) 565-1325

Hutt, Monica

From: George, Camille
Sent: Friday, June 29, 2018 9:43 AM
To: Hutt, Monica; Hill, Bard; McFadden, Clare; Tierney-Ward, Megan; Courcelle, Andre
Subject: update: conflict free case management and clarification about roles between AHS and DVHA

Hi Everyone (and please share with any other staff who need this information):

A lot has happened around the topic of conflict-free case management in the past few weeks and I am writing to update you:

- The topic was raised at the June 14 DAIL Advisory Board meeting as Shawn Skaflestad, Clare and Andre were providing an update on implementation of the CMS HCBS rules. Also in attendance at the meeting were 2 staff from the DD Council that raised the issue, but then members of the DAB were also very interested. At that time, the DAB requested copies of the CM waiver exemption request that was submitted to CMS and any related communication to/from CMS.
- I followed up with AHS Interim Deputy Secretary Clarence Davis with a cc to Selina Hickman. Selina provided some documentation and also included a number of additional AHS staff (including DMH, DVHA, etc). In her communication, Selina raised that CMS had already advised that the way to go about doing this would be to request an amendment to the 1115 waiver and that the plan was to include it with the recently authorized Substance Use Disorder waiver amendment, but that the amendment request re: conflict free case management was not included in that amendment (I later learned at the meeting discussed below that CMS discouraged VT from including it, stating that the topic is very controversial and could slow down the approval of the SUD waiver). It was agreed that we would meet to brief Clarence and come up with a plan.
- In the meantime, the DD Council filed 2 very broad public records requests, 1 with DAIL and 1 with AHS.
- The DD's Council was subsequently withdrawn, as state employees cannot file FOIA requests, but DAIL indicated to DD Council staff Susan Aranoff that I was already working on the request from the DAIL Advisory Board and would share the information with her.
- At the meeting, we briefed Clarence about the rule and the history, background and VT specific complexities related to the conflict-free case management rule. This is when I got additional clarity about the message from CMS that a waiver amendment would need to be submitted and approved.
- We also agreed that Ashley Berliner would do some research about the rule, where things stand, where we have gaps, identify liabilities/risks related to compliance, etc. and then we would come back together to discuss options and come up with a plan moving forward.
- I've made a note to check in with Ashley about conflict free CM in a couple weeks if we have not heard from her by then.

We also had an opportunity to clarify/discuss communication/roles and who needs to be brought into what conversations:

HCBS CQS July 2018 000418

Ena Backus supervises Shawn S (and others, but I didn't get their names) and their group focuses on quality and compliance. Ashley is head of Medicaid Policy. However, since policy, quality and compliance are all intertwined, it was advised that when we have issues that arise related to Medicaid (not just re: the conflict free CM or HCBS rules), that we reach out to both Ena and Ashley and they can determine if and who needs to be involved.

I hope this update is helpful. Please let me know if you have any questions.

Camille George, Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Commissioner's Office
HC 2 South
280 State Drive
Waterbury, VT 05671-2020
Telephone: 802.241.2401 or 802.241.0359
Cell Phone: 802.798-2079
E-mail: camille.george@vermont.gov
http://www.dail.vermont.gov/

The mission of the Vermont Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

ALZHEIMER'S & BRAIN awareness month
alzheimer's association

HCBS CQS July 2018 000419

June is Alzheimer's and Brain Awareness Month! Over 13,000 Vermonters are living with Alzheimer's Disease, but growing evidence indicates that people can reduce their risk of cognitive decline by adopting key lifestyle habits. Learn the 10 Ways to Love Your Brain. If you are concerned about a loved one or yourself, ask your health care provider to perform a brief cognitive assessment. Early screening gives more time for families to plan next steps and access helpful resources and supports. Cognitive screening is included in Medicare's annual Wellness Visit and Medicare also offers a new benefit for dementia planning support. For questions, local resources and support, contact the Alzheimer's Association Vermont Chapter at 1-800-272-3900.

HCBS CQS July 2018 000420

Provider	Provider Type	Program AFC	TBI	AD	Total # Consumers	15%	May-18 NCI Survey	HCBS Validation Status
ACHH	HHA				0	0	15	
BarrePI	AD				0	0		
BenningtonPI	AD				0	0		
CarePartners	AD				0	0		
CHHC	HHA				0	0	8	
CHOICE	TBI	9	25		34	5	19	met May 2018
ChampCommServ	SSA	3			3	0	1	
CSAC	DA	7			7	1	2	met May 2018
CVAA	AAA				0	0	71	
CVCOA	AAA				0	0	24	
CVHHH	HHA				0	0	4	
Eagle Eye	TBI		4		4	1		
ElderlyServices	AD				0	0		
Families First	SSA	4			4	1		
FCHHH	HHA				0	0	13	
Gathering Place	AD				0	0		
Gifford	AD				0	0		
GMSS	SSA	24	9		33	5		
HCRS	DA	1	2		3	0		
HISIP	TBI		7		7	1		
Howard Center	DA	2			2	0	1	
Interage	AD				0	0		
Lamoille	AD				0	0		
LHHH	HHA				0	0	7	
Lincoln Street	SSA	2			2			
Meeting Place	AD				0	0		
MHS	HHA				0	0		
NCSS	DA		4		4	1		
NEKAAA	AAA				0	0	18	
NEKHS	DA	12			12	2	2	met May 2018
OEVNA	HHA				0	0	14	
Oxbow	AD				0	0		
PRIDE	TBI	18	28		46	7	8	met May 2018
Randolph	AD				0	0		
RAVNAH	HHA				0	0	31	
Riverside	AD				0	0		
Senior Sol	AAA				0	0	34	
Springfield	AD				0	0		
SWVCOA	AAA				0	0	53	
UCS	DA	2			2	0	1	
UVS	DA	10			10	2		
VNA CHGI	AD				0	0		
VNA CHGI	HHA				0	0	47	
VNAVTNH	HHA				0	0	17	
Totals		94	79	0	173	26	390	
	15%	14	12	0	26			
		AFC	TBI	AD				

	66
	0.1679
	1755

Provider	Provider Type	Program AFC	TBI	AD	Total # Consumers	15%	May-18 NCI Survey	HCBS Validation Status
ACHH	HHA				0	0	15	
BarrePI	AD				0	0		
BenningtonPI	AD				0	0		
CarePartners	AD				0	0		
CHHC	HHA				0	0	8	
CHOICE	TBI	9	25		34	5	19	met May 2018
ChampCommServ	SSA	3			3	0	1	
CSAC	DA	7			7	1	2	met May 2018
CVAA	AAA				0	0	71	
CVCOA	AAA				0	0	24	
CVHHH	HHA				0	0	4	
Eagle Eye	TBI		4		4	1		
ElderlyServices	AD				0	0		
Families First	SSA	4			4	1		
FCHHH	HHA				0	0	13	
Gathering Place	AD				0	0		
Gifford	AD				0	0		
GMSS	SSA	24	9		33	5		
HCRS	DA	1	2		3	0		
HISIP	TBI		7		7	1		
Howard Center	DA	2			2	0	1	
Interage	AD				0	0		
Lamoille	AD				0	0		
LHHH	HHA				0	0	7	
Lincoln Street	SSA	2			2			
Meeting Place	AD				0	0		
MHS	HHA				0	0		
NCSS	DA		4		4	1		
NEKAAA	AAA				0	0	18	
NEKHS	DA	12			12	2	2	met May 2018
OEVNA	HHA				0	0	14	
Oxbow	AD				0	0		
PRIDE	TBI	18	28		46	7	8	met May 2018
Randolph	AD				0	0		
RAVNAH	HHA				0	0	31	
Riverside	AD				0	0		
Senior Sol	AAA				0	0	34	
Springfield	AD				0	0		
SWVCOA	AAA				0	0	53	
UCS	DA	2			2	0	1	
UVS	DA	10			10	2		
VNA CHGI	AD				0	0		
VNA CHGI	HHA				0	0	47	
VNAVTNH	HHA				0	0	17	
Totals		94	79	0	173	26	390	
	15%	14	12	0	26			
		AFC	TBI	AD				

	66
	0.1679
	1755

First Name	Last Name	Email	Provider Name	HCBS Service
[redacted]			Bennington Project Independence	Adult Day
			CarePartners Adult Day Services	Adult Day
			Elderly Services, Inc.	Adult Day
			Gifford Medical Center Adult Day	Adult Day
			Green Mountain Adult Day Services of Orleans Count	Adult Day
			Interage Adult Day Services	Adult Day
			Lamoille Day Health Services	Adult Day
			Oxbow Senior Independence	Adult Day
			Riverside Life Enrichment Center	Adult Day
			Springfield Area Adult Day Services	Adult Day
			The Gathering Place	Adult Day
			The Meeting Place	Adult Day
			VNA Adult Day Program	Adult Day
			Champlain Community Services	Adult Family Care
			Howard Center	Adult Family Care
			Lincoln Street Inc.	Adult Family Care
			Northeast Kingdom Human	Adult Family Care
			Upper Valley Services	Adult Family Care
			Choice TBI Support Services, Inc.	Adult Family Care
			Counseling Services of Addison	Adult Family Care
			Families First Southern Vermont	Adult Family Care
			Green Mountain Support Services	Adult Family Care
			Health Care and Rehabilitation Services of Southeastern Vermont	Adult Family Care
			HIS Independence Project, Inc.	Adult Family Care
			Northwestern Counseling and Support Services	Adult Family Care
			PRIDE, Inc.	Adult Family Care
			Rutland Mental Health Services,	Adult Family Care
			United Counseling Services	Adult Family Care
			Age Well	Case Management
			Central VT Council on Aging	Case Management
			Northeastern Vermont Area Agency on Aging	Case Management
			Senior Solutions	Case Management
			Southwestern Vermont Council on	Case Management
			Addison County Home Health and Hospice	Case Management
			Central VT Home Health and	Case Management
			Franklin County Home Health	Case Management
			Lamoille Home Health	Case Management
			Manchester Health Services	Case Management
			Caledonia Home Health Care	Case Management
			Orleans-Essex VNA & Hospice, Inc.	Case Management
			Rutland Area Visiting Nurse Association and Hospice	Case Management
			Visiting Nurse Association and Hospice of VT/NH	Case Management
			Visiting Nurse Association of Chittenden and Grand Isle Counties	Case Management

Agency name
Addison County Home Health and Hospice
Apria Healthcare
Ave Maria
Barre Project Independence
Bayada Nurses
Bennington Project Independence
Blue Spruce Home
Brookwood
Brownway Residence
CarePartners Adult Day Services
Central VT Council on Aging
Central VT Home Health and Hospice
Champlain Community Services
Champlain Valley Agency on Aging
Clark's Residential Care Home
Converse Home
Council on Aging for Southeastern Vermont
Counseling Services of Addison County
Davis Home
Eagle Eye Farm
Elderly Services, Inc.
Equinox Terrace
Ethan Allen Residence
Evarts House
Four Seasons Care Home
Franklin County Home Health Agency
Gifford Medical Center Adult Day Center
Green Mountain Adult Day Services of Orleans Count
Health Care and Rehabilitation Services of Southeastern Vermont
Heaton Woods
Hilltop House
HIS Independence Project, Inc.
Holiday House
Holton Home
Interage Adult Day Services
Jim Ringer Home Care
Johnson's Care Home
Keene Medical Products
King's Daughters' Home
Lamoille County Mental Health
Lamoille Home Health
Lincoln House
Living Well
Loretto Home
Manchester Health Services
Manes House
Maple Lane Retirement Home
Maple Terrace
Mayo Manor
Meadows at East Mountain
Michaud Memorial Manor
Misty Heather Morn
Mountain View of Vershire
Northeastern Vermont Area Agency on Aging
Northern Counties Health Care Inc., D/B/A Caledonia Home Health Care
Northwestern Counseling and Support Services
Orleans-Essex VNA & Hospice, Inc.

Agency name
Our House at Park Terrace
Our House Residential Care Home
Our House Too Residential Care Home
Our Lady of Providence
Our Lady of the Meadows
Out & About
Oxbow Senior Independence Program
Pillsbury Manor – Gazebo Apartments
Pillsbury Manor North
Pillsbury Manor South
Pine Knoll Community Care Home
PRIDE, Inc.
Riverbend Residential Care Home
Rivers Edge Community Care Home
Riverside Life Enrichment Center
Riverview Life Skills Center
Rutland Area Visiting Nurse Association and Hospice
Rutland Manor
Rutland Mental Health Services, Inc.
Scenic View Community Care Home
Shard Villa
Southwestern Vermont Council on Aging
Spaulding's Care Home
Springfield Area Adult Day Services
Squier House
St. Joseph Kervick Residence
St. Joseph's Residential Care Home
Sterling Area Service, Inc.
Sterling House at Richmond
Stoughton House
The Assisted Living Residence at Cathedral Square Senior Living
The Gathering Place
The Medical Store
The Meeting Place
United Counseling Services
Upper Valley Services
Valley View Home
Vergennes Residential Care
Vernon Hall Retirement Residence
Victorian House Residence
Village at Fillmore Pond
Visiting Nurse Association and Hospice of Southwestern Vermont Health Care
Visiting Nurse Association and Hospice of VT/NH
Visiting Nurse Association of Chittenden and Grand Isle Counties
VNA Adult Day Program - Prim Road
Washington County Mental Health Services, Inc.
West River Valley ALR
Willows of Windsor
Windover House Inc.
Wintergreen Residential Care Home

Estimate As of November 17, 2017		15%	# of
Service Totals	**#**	**Sample**	Providers
Adult Family Care=	90	**14**	10
Adult Day=	200	**30**	14
TBI=	85	**13**	11
Grand Total=	**375**	**56**	35
Non-HCBS ERC Total =	500	75	72

(NOTE: ERC optional phase 2 of CFC Work Plan)

First Name	Last Name	Email	Provider Name	HCBS Service
[redacted]			Eagle Eye Farm	TBI
			Choice TBI Support Services, Inc.	TBI
			Counseling Services of Addison County	TBI
			Families First Southern Vermont	TBI
			Green Mountain Support Services	TBI
			Health Care and Rehabilitation Services of Southeastern Vermont	TBI
			HIS Independence Project, Inc.	TBI
			Northwestern Counseling and Support Services	TBI
			Upper Valley Services Inc.	TBI
			PRIDE, Inc.	TBI

Participant Review Sheet

Adult Day Center:	
Participant :	
Date of Review:	
Reviewer:	

		Standard	How Reviewed	Comments and Findings	Met	Unmet
		The Adult Day Center shall provide and demonstrate to each participant following:	Observation, Participant records			
	I.B.1	1. Respect, dignity and a sense of well being for the participants.	Observation, Participant records			
	I.B.2	2. Respect of individual rights, strengths, values, privacy and preferences, encouraging participants to direct and participate in their own plan of care and services to the fullest extent.	Observation, Participant records			
	I.B.3	3. Promotion of the participants optimal level of independence in a community based setting.	Observation, Participant records			
	I.B.4	4. Maintenance and where possible enhance the participants' functioning as long as possible, preventing or delaying a more restricted lifestyle.	Observation, Participant records			
	I.B.5	5. Foster the development and maintenance of social skills and interaction.	Observation, Participant records			
	I.B.6	6. Support, respite and education services for family members, caregivers and/or legal representatives.	Observation, Participant records, discussion with family			
	I.B.7	Serve as an integral part of the community service network.	Participant records, discussion with community service network			
		Participant Record				
	IX.A & B	Record is available in a timely fashion.	Record Examination			
	IX.C	Record is legible.	Record Examination			
	IX.D.1	Intake information adequate to provide care safely and appropriately.	Record Examination			
	IX.D.2	Record includes the required medical information.	Record Examination			

Participant Review Sheet

Adult Day Center:	
Participant :	
Date of Review:	
Reviewer:	

		Standard	How Reviewed	Comments and Findings	Met	Unmet
	IX.D.3	Includes a signed acknowledgement of the receipt of the policies outlined in Section X.	Record Examination			
	IX.D.4	The assessment form designated by the Department shall be completed for each participant at reasonable times and locations of convenience to the individual.	Record Examination			
	IX.D.4.a	Initial assessments, including the ILA, shall be completed within the first thirty (30) sessions of participation at the adult day center or within ninety (90) days of enrollment, whichever occurs first.	Record Examination			
	IX.D.4.b	Reassessments shall be completed within thirty (30) days of the anniversary of the initial assessment, and whenever significant changes occur.	Record Examination			
	IX.D.4.c	The health section of the assessment may only be completed by a registered nurse (RN) or a licensed practical nurse (LPN). The health section must be signed by the RN sho completed it. If an LPN completed the health section, a RN must review and sign it.	Record Examination			
	IX.D.5	The process for developing the adult day Plan Of Service (POS) should be an includive, person-centered process that enables the adult day center to serve the participant to the best of its ability. The intial POS shall be written within ninety (90) days from the beginning of adult day services.	Participant records, discussion with Participants and staff			

Participant Review Sheet

Adult Day Center:	
Participant :	
Date of Review:	
Reviewer:	

		Standard	How Reviewed	Comments and Findings	Met	Unmet
	IX.D.6	Documentation that a review of each participant's assessment, plan of service, and progress notes has occurred at least once every six (6) months.	Record Examination			
	IX.D.7	Modifications identify specific and individualized need for service modification based on the unique needs of the participants or to address health, safety, and/or welfare concerns.	Record Examination			
	IX.D.8	The monthly progress note includes the name, signature, and position of the individual writing the note.	Record Examination			
	IX.D.8.a-c	The monthly progress note reflects a review of the entire service plan and any relevant information such as progress, changes in goals or any modifications to the person-centered plan.	Record Examination			
	IX.D.9	Each participant file reviewed included a plan for the end of service, as appropriate.	Record Examination			
	IX.D.10	Each participant file reviewed included a completed permission for release of information using the form designated by the Department.	Record Examination			
	IX.D.13	If a variance was necessary regarding Adult Day funding issues, both the written request and Department approval was included in each participant file reviewed.	Record Examination			

Participant Review Sheet

Adult Day Center:	
Participant :	
Date of Review:	
Reviewer:	

		Standard	How Reviewed	Comments and Findings	Met	Unmet
	IX.D.14	Each participant file reviewed included correspondence with family members, caregivers, legal representatives, or other community agencies/primary care providers, as appropriate.	Record Examination			
	IX.D.15	Incident reports are reviewed and filed as indicated by center policy, as appropriate.	Record Examination			
		Health Section				
	XII.F.11	A first aid kit available.	DAIL Staff will review on site.			
	IX.D.2.a	A request for a Health summary is submitted to the physician within 30 days of the start of services and minimally annually and as needed.	DAIL Staff will review on site.			
	IX.D.2.a. i-vi	Physician's orders are obtained, as necessary, prior to any medication administration or assistance or any medical treatments.	DAIL Staff will review on site.			
	IX.D.11	Center accurately and completely documents daily attendance.	Please have current attendance sheets available for review.			
	X.a.vi	Delegation, if being utilized , is documented as required.	DAIL Staff will review on site.			
	X. a-c	Health Coordination, Social Work, Activities	Reference Job Descriptions and Personnel files in Section V.A.			

Kennedy, Alice

From: JBohen@springfieldmed.org
Sent: Friday, January 27, 2017 3:37 PM
To: Tierney-Ward, Megan
Subject: Adult Day Standards and AD Director Comments.

Megan,
I have heard back from a few of the AD Directors re: your request to post the AD Standards to the website as final.

See below: these are concerns from the other members and as I understand that some of these new standards are federal law but thought you would like to see the comments and reply. We also don't have the assessment tool which is referred to in the standards.

Each center should be able to create their own policy so as to create a safe space for all of our participants. I have participants with particular concerns when it comes to visitors, putting us and the participant in a liable position with the way the current standard is stated. The right to have visitors at any time. I would like the ability to request that participants call a day ahead to provide notice of visitors so as to make arrangements if necessary for participants that may be negatively affected by someone else's visitors.

As far as visitors it does state that we can "describe(s) the process for potential modifications to said participant's rights." I would think that a center could outline in their policy that visitors needed to check-in. I hope that the way they've outlined this it will give us the flexibility that we want/need.

Section: IV: Quality Management: There is no self assessment tool listed that has been designed for us to use or tailor.

Section VII & VIII: Regarding Program & Participant Policies: The right to have visitors at any time. We have had several discussions about this policy can/could cause disruptions/safety concerns. Can we add a section that states all visitors must check in at the front door to be sure that the participant is in agreement to participate in a visitation and if visitors cause any concerns or problems ..... just a thought.

Section XI: Nutrition & Food Services: To put in something about when wanting visitors to come for lunch that they must call ahead to schedule it. To prepare the correct number of meals.

I am somewhat concerned as to the language regarding Modifications and that broad brush that it includes all of the participant rights...not just Section X/b....in regards to Direct Care.....
....thereby making a 'Visitors policy' too broad and not being a 'specific and individualized' need, etc.

In addition, I am concerned that we do not have the assessment tool ..... The Standards and the Tool should be issued simultaneously..... Especially as the Standards specifically refer to the Vermont Act 124 and the Vermont Government Accountability Office....."specific guidance'.....

J.

JoAnne C. Bohen, BA
Director of Springfield Area Adult Day Services
266 River Street
Springfield, VT 05156
phone: 802-885-9881
fax: 802-885-6925

http://www.springfieldmed.org

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Choices for Care Adult Family Care Home: Authorized Agency Provider List — December 2017

Authorized Agency	Address	Contact
Champlain Community Services	512 Troy Ave, Colchester, VT 05446	Karen Cienchanowicz 655-0511 X 120 Kciechanowicz@ccs-ct.org
Choice Brain Injury Support Services	5 School Avenue, Montpelier, VT 05601	Nicole Pierce 225-6232 npierce@htomail.com
Counseling Services of Addison County, Inc.	109 Catamount Park, Middlebury, VT 05753	Paula Dougherty 388-4021 pdougherty@csac-vt.org
Families First	26 Elliot Terrace, Brattleboro, VT 05301	David Wheeler 275-4919 david@familiesfirstvt.com
Green Mountain Support Services (*Formerly Sterling Area Services*)	109 Professional Dr., Morrisville, VT 05661	Marilyn Carter 888-7602 marilync@sterlingarea.org
Health Care and Rehab Services (HCRS)	390 River Street, Springfield, VT 05156	Katie Gilcris 886-4567 X 2710 kgilcris@hcrs.org
Head Injury Stroke Independence Project	1409 US 7 Wallingford, VT AKA Lenny Burke Farm	Kevin Burke 353-8850 B1840house@aol.com
Howard Center	322 St. Paul Street, Burlington, VT 05401	Delaina Norton 488-6543 delainan@howardcenter.org
Lincoln Street Incorporated	374 River Rd., Springfield, VT 05156	Bart Mair 886-1833 bmairl@lincolnstreetinc.org
Northeast Kingdom Human Services	P.O. Box 724, Newport, VT 05855	Cindy Cook 748-3181 ccook@nkhs.net
Northwestern Counseling and Support Services	107 Fisher Pond Rd., St. Albans, VT 05478	Amber Schaeffler 393-6641 amber.schaeffler@ncssinc.org
PRIDE	P.O. Box 969, Barre, VT 05641	Kim Daniels 479-5801 kdaniels@tds.net
Rutland Mental Health Services	78 South Main St., Rutland, VT 05702	Michel Kirsten 786-7305 mkersten@rmhsccn.org
United Counseling Services	10 Ledghill Hill Dr., Bennington, VT 05201	Bonnie Jamieson 442-5491 X 294 bjamieson@ucsvt.org
Upper Valley Services	P.O. Box 4409, White River Junction, VT 05001	Bill Ashe 222-9235 jgustin@uvs-vt.org

Vermont Association of Adult Day Services (VAADS)
Member List

ADDISON COUNTY
Elderly Services, Inc.
Joanne Corbett, Executive Director
112 Exchange St.
Middlebury, VT 05753
Mailing Address:
PO Box 581
Middlebury, VT 05753-0581
388-3983 388-0427 *fax*
mail@elderlyservices.org
www.elderlyservices.org

BENNINGTON COUNTY
Bennington Project Independence
Linda Wichlac, Executive Director
614 Harwood Hill
Bennington, VT 05201
Mailing address:
PO Box 1504
Bennington, VT 05201
442-8136 447-8491 *fax*
Linda.Wichlac@bpiads.org
www.bpiads.org

CALEDONIA COUNTY
Riverside Life Enrichment Center
Leo H. Peter Coutu, Executive Director
2104 East Burke Rd.
Lyndonville, VT 05851
626-3900 626-3939 *fax*
Rlec@sover.net
www.theriversidecenter.org

CHITTENDEN COUNTY
VNA Adult Day Program
Diane Olechna, ADP Manager
1110 Prim Rd.
Colchester, VT 05446
860-4407 860-4477 *fax*
olechna@vnacares.org
www.vnacares.org

FRANKLIN COUNTY
CarePartners Adult Day Center, Inc.
Sue Chase, Executive Director
34 Franklin Park West
St. Albans, VT 05478
527-0548 527-2399 *fax*
sue@carepartnersvt.org
www.carepartnersvt.org

LAMOILLE COUNTY
Lamoille Area Adult Day Services
11 Court St.
Morrisville, VT 05661
888-7045 888-8809 *fax*
rlec@sover.net Attn: Peter Coutu
www.outandaboutvt.org

ORANGE COUNTY
Oxbow Senior Independence Program
Julia O'Donnell, Executive Director
4621 Main St., South
Newbury, VT 05051
Mailing Address
PO Box 25
Newbury, VT 05051-0025
866-5465 866-5465 *fax*
osipads@gmail.com
www.osipads.org

ORANGE COUNTY
Gifford Medical Center Adult Day Center
Judy Santamore, Adult Day Director
1823 Route 107
Bethel, VT 05032
Mailing Address:
PO Box 2000
Randolph, VT 05060-2000
234-2165 234-5507 *fax*
jsantamore@giffordmed.org

RUTLAND COUNTY
InterAge Adult Day Program
Loryn Hamilton, Director
230 No. Main St., Suite 5
Rutland, VT 05701
773-2011 773-2032 *fax*
Lham802@aol.com

WASHINGTON COUNTY
Barre Project Independence
Dee Rollins, Director
81 No. Main St., Suite 1
Barre, VT 05641
PO Box 417
East Barre, VT 05649-0417
476-3630 479-9261 *fax*
dee@pibarre.org

WINDHAM COUNTY
The Gathering Place
Mary Fredette, Executive Director
30 Terrace St.
Brattleboro, VT 05301
254-6559 257-2859 *fax*
info@gatheringplacevt.org
www.gatheringplacevt.org

WINDSOR COUNTY
Springfield Area Adult Day Services
JoAnne Bohen, Director
266 River St.
Springfield, VT 05156
885-9881 885-6925 fax
jbohen@springfieldmed.org

Revised 12/7/16

Vermont Association of Adult Day Services (VAADS)
Member List

ADDISON COUNTY
Elderly Services, Inc.
Joanne Corbett, Executive Director
112 Exchange St.
Middlebury, VT 05753
Mailing Address:
PO Box 581
Middlebury, VT 05753-0581
388-3983 388-0427 *fax*
mail@elderlyservices.org
www.elderlyservices.org

CALEDONIA COUNTY
Riverside Life Enrichment Center
Leo H. Peter Coutu, Executive Director
2104 East Burke Rd.
Lyndonville, VT 05851
626-3900 626-3939 *fax*
Rlec@sover.net
www.theriversidecenter.org

FRANKLIN COUNTY
CarePartners Adult Day Center, Inc.
Sue Chase, Executive Director
34 Franklin Park West
St. Albans, VT 05478
527-0548 527-2399 *fax*
sue@carepartnersvt.org
www.carepartnersvt.org

ORANGE COUNTY
Oxbow Senior Independence Program
Julia O'Donnell, Executive Director
4621 Main St., South
Newbury, VT 05051
Mailing Address
PO Box 25
Newbury, VT 05051-0025
866-5465 866-5465 *fax*
osipads@gmail.com
www.osipads.org

BENNINGTON COUNTY
Bennington Project Independence
Linda Wichlac, Executive Director
614 Harwood Hill
Bennington, VT 05201
Mailing address:
PO Box 1504
Bennington, VT 05201
442-8136 447-8491 *fax*
Linda.Wichlac@bpiads.org
www.bpiads.org

CHITTENDEN COUNTY
VNA Adult Day Programs (3 sites)
Pinecrest (Essex Jct.,); Grand way (South Burlington); Prim Road (Colchester)
Diane Olechna, ADP Manager
1110 Prim Rd.
Colchester, VT 05446
802-860-4458 Fax: 802-860-4477
olechna@vnacares.org
www.vnacares.org

LAMOILLE COUNTY
Lamoille Area Adult Day Services
11 Court St.
Morrisville, VT 05661
888-7045 888-8809 *fax*
rlec@sover.net Attn: Peter Coutu
www.outandaboutvt.org

ORANGE COUNTY
Gifford Medical Center Adult Day Center
Judy Santamore, Adult Day Director
1823 Route 107
Bethel, VT 05032
Mailing Address:
PO Box 2000
Randolph, VT 05060-2000
234-2165 234-5507 *fax*
jsantamore@giffordmed.org

ORLEANS COUNTY
The Meeting Place
Jen Barnes, Director
100 Second Street
Newport, VT 05855
PO Box 250
Newport, VT 05855
802-334-7604 ext.104
802-334-1347 *fax*
Jennifer.barnes@nekhc.com

RUTLAND COUNTY
InterAge Adult Day Program
Loryn Hamilton, Director
230 No. Main St., Suite 5
Rutland, VT 05701
773-2011 773-2032 *fax*
Lham802@aol.com

WINDHAM COUNTY
The Gathering Place
Mary Fredette, Executive Director
30 Terrace St.
Brattleboro, VT 05301
254-6559 257-2859 *fax*
info@gatheringplacevt.org
www.gatheringplacevt.org

ORLEANS COUNTY
Green Mountain Adult Day
Linda Thayer, Director
148 Prouty Drive
Newport, VT 05855
802-334-3188
802-334-1548 *fax*
gmads@sover.net

WASHINGTON COUNTY
Barre Project Independence
Sarah Crane, Director
81 No. Main St., Suite 1
Barre, VT 05641
PO Box 417
East Barre, VT 05649-0417
476-3630 479-9261 *fax*
scrane@pibarre.giffordhealthcare.org

WINDSOR COUNTY
Springfield Area Adult Day Services
JoAnne Bohen, Director
266 River St.
Springfield, VT 05156
885-9881 885-6925 fax
jbohen@springfieldmed.org

Revised 5/22/17

Authorized Agencies for Adult Family Care

- **Champlain Community Services**, Colchester, Vermont
  ☎ **CONTACT 802-655-0511.**
  Online at http://ccs-vt.org/
- **CHOICE Brain Injury Support Services**, Montpelier, Vermont
  ☎ **CONTACT** 802-622-8122
  Online at http://www.choicetbisupportservices.com/
- **Counseling Services of Addison County**, Middlebury, Vermont
  ☎ **CONTACT (802) 388-7641**
  Online at http://www.csac-vt.org/
- **Families First**, White River Junction, Vermont
  ☎ **CONTACT (802) 464-9633**
  Online at http://familiesfirstvt.weebly.com/
- **Health Care and Rehabilitative Services**, Springfield, Vermont
  ☎ **CONTACT (802) 886-4500**
  Online at http://www.hcrs.org/
- **Head Injury Stroke Independence Project** (no website) Rutland, VT
  ☎ **CONTACT** 1-802-353-8850
- **Howard Center**, Burlington, Vermont
  ☎ **CONTACT (802) 488-6000**
  Online at http://www.howardcenter.org/home
- **Lincoln Street Incorporated**, Springfield, Vermont
  ☎ **CONTACT 1-888-545-9533**
  Online at http://www.lincolnstreetinc.org/
- **Northeast Kingdom Human Services**, Newport, Vermont
  ☎ **CONTACT (802) 748-3181**
  Online at http://www.nkhs.org/
- **Northwestern Counseling and Support Services**, St. Albans, Vermont
  ☎ **CONTACT 1-800-834-7739**
  Online at http://www.ncssinc.org/
- **PRIDE Inc**, Barre, Vermont
  ☎ **CONTACT (802) 479-5801**
  Online at http://www.pridetbi.com/home
- **Rutland Mental Health Services**, Rutland, Vermont
  ☎ **CONTACT (802) 775-2381**
  Online at http://www.rmhsccn.org/
- **United Counseling Services**, Bennington, Vermont
  ☎ **CONTACT (802) 442-5491**
  Online at http://www.ucsvt.org/
- **Upper Valley Services** (no website), Bradford, Vermont
  ☎ **CONTACT** 1-802-222-9235

Care Plan Monitoring Report

- Active AFC sorted by Provider 2.6.18

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Community Services			
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Addison
Agency: Champlain Community Services: 3 unduplicated consumers			
Agency: Choice TBI Support services			
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Addison
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Addison
[redacted]			Washington
Agency: Choice TBI Support services: 9 unduplicated consumers			
Agency: Counseling Service of Addison County (CSAC)			
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
Agency: Counseling Service of Addison County (CSAC): 7 unduplicated consumers			
Agency: Families First			
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
Agency: Families First: 4 unduplicated consumers			
Agency: Green Mountain Support Services, Inc.			
[redacted]			Caledonia
[redacted]			Washington
[redacted]			Bennington
[redacted]			Lamoille
[redacted]			Lamoille

Care Plan Monitoring Report

- Active AFC sorted by Provider 2.6.18

Full Name	Primary Phone	Town of Residence	County
Agency: Green Mountain Support Services, Inc.			
[redacted]			Washington
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Caledonia
[redacted]			Franklin
[redacted]			Lamoille
[redacted]			Orleans
[redacted]			Lamoille
[redacted]			Orange
[redacted]			Orleans
[redacted]			Chittenden
[redacted]			Orleans
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Lamoille
[redacted]			Orleans
Agency: Green Mountain Support Services, Inc.: 24 unduplicated consumers			
Agency: Health Care and Rehabilitation Services of SE VT			
[redacted]			Windsor
Agency: Health Care and Rehabilitation Services of SE VT: 1 unduplicated consumer			
Agency: Howard Center			
[redacted]			Addison
[redacted]			Chittenden
Agency: Howard Center: 2 unduplicated consumers			
Agency: Lincoln Street Incorporated			
[redacted]			Windsor
[redacted]			Windsor
Agency: Lincoln Street Incorporated: 2 unduplicated consumers			
Agency: Northeast Kingdom Human Services (Newport)			
[redacted]			Orleans
Agency: Northeast Kingdom Human Services (Newport): 1 unduplicated consumer			
Agency: Northeast Kingdom Human Services (St. Johnsbury)			

Care Plan Monitoring Report

- Active AFC sorted by Provider 2.6.18

Full Name	Primary Phone	Town of Residence	County
Agency: Northeast Kingdom Human Services (St. Johnsbury)			
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Orange
[redacted]			Orleans
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Washington
[redacted]			Caledonia
Agency: Northeast Kingdom Human Services (St. Johnsbury): 11 unduplicated consumers			
Agency: PRIDE Inc			
[redacted]			Washington
[redacted]			Caledonia
[redacted]			Orange
[redacted]			Washington
[redacted]			Franklin
[redacted]			Windsor
[redacted]			Washington
[redacted]			Addison
[redacted]			Franklin
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Orange
[redacted]			Orange
[redacted]			Washington
[redacted]			Orange
Agency: PRIDE Inc: 18 unduplicated consumers			
Agency: United Counseling Services (UCS)			
[redacted]			Bennington
[redacted]			Bennington
Agency: United Counseling Services (UCS): 2 unduplicated consumers			
Agency: Upper Valley Services			
[redacted]			Chittenden

Care Plan Monitoring Report

- Active AFC sorted by Provider 2.6.18

Full Name	Primary Phone	Town of Residence	County
Agency: Upper Valley Services			
■	[redacted]		Chittenden
■			Orange
■			Caledonia
■			Orange
■			Franklin
■			Caledonia
■			Caledonia
■			Addison
■			Addison

Agency: Upper Valley Services: 10 unduplicated consumers

Summary:	94 consumers

Total : $564,570.20

Vermont Certified Area Agencies on Aging

- **For information from anywhere in Vermont call the Senior Helpline.**
  ☎ **CONTACT** 1-800-642-5119
  💻 Online at http://www.vermontseniors.org/

- **Area Agency on Aging for Northeastern Vermont**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-748-5182
  💻 Online at http://nekseniors.org/

- **Central Vermont Council on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-877-379-2600
  💻 Online at http://www.cvcoa.org/

- **Champlain Valley Agency on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-865-0360
  💻 Online at http://www.cvaa.org/

- **Senior Solutions-Council on Aging for Southeastern Vermont**
  ☎ **CONTACT** 1-800-642-5119 or 1-866-673-8376
  💻 Online at http://www.seniorsolutionsvt.org/

- **Southwestern Vermont Council on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-786-5990
  💻 Online at http://www.svcoa.org/

Vermont Certified Area Agencies on Aging

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  ☎ **CONTACT** 1-800-642-5119
  💻 Online at http://www.vermontseniors.org/

- **Area Agency on Aging for Northeastern Vermont**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-748-5182
  💻 Online at http://nekseniors.org/

- **Central Vermont Council on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-877-379-2600
  💻 Online at http://www.cvcoa.org/

- **Champlain Valley Agency on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-865-0360
  💻 Online at http://www.cvaa.org/

- **Senior Solutions-Council on Aging for Southeastern Vermont**
  ☎ **CONTACT** 1-800-642-5119 or 1-866-673-8376
  💻 Online at http://www.seniorsolutionsvt.org/

- **Southwestern Vermont Council on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-786-5990
  💻 Online at http://www.svcoa.org/

Vermont Certified Area Agencies on Aging (AAA)

- **For information from anywhere in Vermont call the Senior Helpline.**
  ☎ **CONTACT** 1-800-642-5119
  💻 Online at https://www.vermont4a.org/

- **Age Well**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-865-0360
  💻 Online at http://www.agewellvt.org/

- **Area Agency on Aging for Northeastern Vermont**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-748-5182
  💻 Online at http://nekseniors.org/

- **Central Vermont Council on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-877-379-2600
  💻 Online at http://www.cvcoa.org/

- **Senior Solutions-Council on Aging for Southeastern Vermont**
  ☎ **CONTACT** 1-800-642-5119 or 1-866-673-8376
  💻 Online at http://www.seniorsolutionsvt.org/

- **Southwestern Vermont Council on Aging**
  ☎ **CONTACT** 1-800-642-5119 or 1-802-786-5990
  💻 Online at http://www.svcoa.org/

ARIS Solutions – Fiscal Employer Agent
72 South Main Street
White River Junction, VT 05001
Toll Free Phone #: 1-800-798-1658
General email: financial@arissolutions.org
Jennifer Garabedian, Director
jenniferg@arissolutions.org

Transition II Contact Information – Flexible Choices Consultant Agency
346 Shelburne Road
Burlington, VT 05401
1-866-572-7127
Kara Artis, Executive Director
Michelle Brannan, lead coordinator
michelle@transitionii.com
1-802-864-7961

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Tuesday, August 01, 2017 3:13 PM
To: AHS - DAIL ASD
Cc: George, Camille; Hutt, Monica
Subject: ASD Monthly Update - August 2017

August 2017 ASD Monthly Update

AARP LONG-TERM SERVICES & SUPPORTS SCORECARD

In June, AARP released its 2017 State Scorecard on Long-Term Services and Supports (LTSS); Picking up the Pace of Change: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.

I am proud to report that Vermont was ranked 3rd overall in the nation in the delivery of long-term services and supports, showing improvement in Affordability & Access, Choice of Setting & Provider and Support for Family Caregivers. In 2014, Vermont ranked 6th and in 2011 Vermont ranked 11th.

The AARP Scorecard, published every three years, is a compilation of state data and analysis—designed to showcase measures of state performance for creating a high-quality system of care to drive progress toward improvement in services for older adults and people with physical disabilities, and their family caregivers.

Some of the contributing work by AHS, DAIL and its partners include the expansion of Medicaid services allowing more people to access critical LTSS, the large variety of Medicaid funded options for Vermonters who want to receive their services in a less expensive home-based setting, and the variety of family caregiver and respite supports provided through Medicaid programs and Older Americans Act funded services.

LONG-TERM SERVICES & SUPPORTS PROGRAM NOTES

QUALITY MANAGEMENT UPDATES

- TBI standards being aligned with HCBS regulations and CFC program standards.
- [redacted]
- Working with an adult day in Newport that is co-located in a nursing facility, which is not allowed by the new federal HCBS regulations.

STATE PLAN ON AGING

The State Unit on Aging is working with a contractor, Kelly Melekis, to perform a state-wide needs assessment on services for older Vermonters. This assessment will inform the process of revising the Vermont State Plan by October 2018.

[redacted]

"The month of August had turned into a griddle where the days just lay there and sizzled."
— **Sue Monk Kidd, The Secret Life of Bees**

Megan Tierney-Ward
Adult Services Division Director

NEW ASD Website: http://asd.vermont.gov/
NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. *Thank you.*

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Wednesday, October 11, 2017 11:00 AM
To: Courcelle, Andre; Woods, Mary
Subject: ASDPrioritiesSFY18.docx
Attachments: ASDPrioritiesSFY18.docx

This is the draft document we will use at today's supervisor's meeting.

Adult Services Division Priorities: SFY18

ASD priorities align with the following AHS strategic areas:

- ***Promotion of the health, well-being and safety of our communities***
- ***Enhancement of program effectiveness and accountability***

Units	Description	Priority Level 1=highest 2=medium 3=low	Lead	Timeframe
Long-Term Services & Supports Unit	1. Companion/Respite Variances – process improvement			
	2. Fix SAMS CFC care plans			
	3. CFC application process improvement – eliminate waste			
	4. Align ERC standards/manual with DLP regulations			
	5. Revise ILA to align with HCBS regs and person-centered care plan development			
	6. High Tech – process improvement			
Quality Management Unit	1. HCBS Rules Alignment Work - Finalize TBI plan - Universal person-centered care plan documentation			
	2. TBI quality work plan			
	3. ERC quality work plan			
	4. ARIS contract and EVV			
	5. Rewarding Work DII contract and website improvement			
	6. National Core Indicators implementation			
Money Follows the Person Unit	1. Phase down process			
	2. Initiate work re: sustainability plan			
	3. Limited positions: strategize long-term plans			
	4. Improvement projects			
	5. Workforce Project			
State Unit on Aging	1. Renew State Plan on Aging			
	2. Reframing Aging Project			
	3. ADRC = develop final work plan			

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	4. OAA Policy/Procedure Manual: Sections for each thing related to OAA that we are responsible for monitoring.			
	5. Falls Prevention Project			
	6.			

NOTE: This table does not include daily operations of programs, contracts and grants.

Priority Level:

1 = Highest Priority: Items that have the greatest impact on consumers' well-being or are mandated by federal/state law.

2 = Medium: Items that have an indirect effect on consumers and/or may improve program operations/processes.

3 = Low: Items that have little to no impact on consumers and will likely have no effect on improving ASD program operations/process.

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VERMONT

Overview

The Centers for Medicare and Medicaid Services (CMS) is responsible for making rules about Medicaid services. In 2014, CMS made new rules that help people who get Medicaid services. The new CMS rules protect your choice about where services are received. The new CMS rules also make sure that services:

- Are integrated in and give full access to the community, which is known as "Community Integration";
- Provide rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Support individual decisions;
- Let you choose what services you need; and
- Who provides the services to you.

The new CMS rules also require that you must have a written agreement if you live in a provider-run residential setting. This agreement must protect your rights in the same way it does for other renters and program participants. Before your rights can be modified, a needs assessment must be completed. You must be asked to agree to the needs assessment. The changes must also be justified in your individualized plan or support agreement.

You have been randomly selected to give us your opinion about the place where you currently live. Your participation for this survey is voluntary. Your opinions are very important. We hope you will choose to answer the survey. Your answers will help us understand how well your provider meets the new CMS rules.

Questions are organized into the following sections:

1. Information about you and where you receive services;
2. Physical characteristics about where you live;
3. Integration with the community;
4. Privacy, dignity and respect;
5. Individual control, decision-making and independence;
6. Your rights with respect to where you live.

Instructions for Interviewer

Most of the questions are to be asked of the member and/or member's representative. A small portion are to be answered by **the assessor based on his/her observation of the setting. These questions are flagged** as, "To be completed by Interviewer".

The survey is designed to return yes/no answers to each question. If the individual responding to questions struggles to understand the question, examples or prompts to help clarify the question are included for **many of the questions. To ensure that all consumers are answering the same question, please try to use** first question as listed in the interview before moving on to additional prompts or examples. If the individual does not appear to understand the question after additional prompts or provides conflicting detail for the same question mark the response as "D/K".

This survey is designed for multiple types of residential settings, you will need to customize the **terminology based on the person and type of setting you are visiting. For example in some cases, "housemate" may be more appropriate than "roommate"; "home" may be more appropriate than "room". In some cases, the provider may be a residential care or group home name "The Pines" and in other cases a** family care home "The Smith's"; please use whatever name is most familiar to the person being interviewed. As you refer the "the provider" throughout the questions, please note that:

- Each question allows you to add a comments or observations. You are not required to add comments; however, if you feel that there are items needed for follow-up or requiring clarification that is important to the results, please use the comment box to add that information.
- The first section of the survey requires you fill out demographic information about the consumer, provider and location. DAIL will provide this information to you for each person and/or the provider staff assigned to work with you. Please make sure that you have the necessary details to fill out the demographic information in order to complete the survey.

Questions regarding the assessment should be directed to:

Agency of Human Services:
Shawn Skaflestad, Quality Improvement Manager
(802) 241-0961
Shawn.skaflestad@vermont.gov

Developmental Disabilities Services Division:
Chris O'Neill, DAIL- DDSD Quality Management Team Leader
(802) 241-0332
Chris.ONeil@vermont.gov

Adult Services Division:
Quality & Provider Relations Director (802) 786-2516
Andre.Courcelle@vermont.gov

Section 1- DEMOGRAPHIC INFORMATION

To be completed with information provided by DAIL and/or Provider.

Member's Last Name: _____

Member's First Name: _____

Who is completing the survey? **Kathy Hamilton - DAIL employee**

Last Name of Person Assisting: _____

First Name of Person Assisting: _____

Relationship to Participant: _____

Date of Enrollment with Provider: _____

Provider Name and Mailing Address (This question is required.)

Provider or Host Agency Name: _____

Provider Contact Name: _____

Street or PO Box: _____

City: _____

State: _____

Zip Code: _____

Program (choose one):

- ____Choices for Care Program (choose one setting)
  - ___Adult Day Setting
  - ___Adult Family Care Setting
  - ___Enhanced Residential Care Setting

-OR-

- ____Traumatic Brain Injury Program (Choose one setting)
  - ___Residential Care Home
  - ___Shared Living
  - ___Staffed Living
  - ___Supervised Living

Provider Service Location (This question is required.)

Location Name: _____

Street or PO Box: _____

City: _____

State: _____

Zip Code: _____

Interviewer Completing Self-Assessment *This question is required .

Last Name: **Hamilton**

First Name: **Kathy**

Office Telephone: **802-442-9191**

Email: **kathleen.hamilton@vermont.gov**

2 - PHYSICAL LOCATION CHARACTERISTICS

This section is to be completed entirely through Interviewer observation.

All questions are required unless noted otherwise.

2.1 Is the residence/service setting located In a building that is also a publicly or privately operated facility that provides Inpatient institutional treatment (NF, IMO, ICF/1Dor hospital)?

___Yes
___No

Comments:

2.2 Is the residence/service setting located in a building on the grounds of, or Immediately adjacent to, a public institution (e.g. prison or State-operated hospital)?

___Yes
___No

Comments:

2.3 Is the residence/service setting one of multiple locations that the provider owns or operates on the same street? (Answer "no" if the residence/service setting is a duplex or multiplex and there are no others owned or operated by the provider on the street.)

___Yes
___No

Comments:

2.4 Is the residence/service setting located in a gated/secured community for persons with disabilities?

___Yes
___No

Comments:

2.5 Is the residence/service setting located in a farmstead or disability-specific community?

___Yes
___No

Comments:

2.6 Is the residence/service setting designed specifically for persons with disabilities? (Please note for community based home settings developed specifically and uniquely for one or two residents based on their needs and preferences, please check "No")

___Yes
___No

Comments:

2.7 Are the individuals who reside/receive services in the setting primarily people with disabilities? (Please note for community-based home settings developed specifically and uniquely for one or two residents based on their needs and preferences, please check "No")

___Yes
___No

Comments:

2.8 Is the service setting located in the same building as an educational program or school?

___Yes
___No

Comments:

2.9 Is the setting located among other residential buildings, private businesses, retail businesses, restaurants, doctors' offices etc., so as to facilitate integration with the greater community? (For rural communities if the setting is commensurate with other locations seen in community or neighborhood, please respond "yes")

___Yes
___No

Comments:

2.10 Notwithstanding DAIL approved security measures, is the setting free from gates, Velcro strips, locked doors and other barriers preventing residents from entering or exiting certain areas of the setting?

___Yes
___No

Comments:

2.11 Are supports, such as grab bars, wheelchair ramps, bathroom seats and viable emergency exits, provided for individuals who need supports to move about the setting as they choose?

___Yes
___No

Comments:

2.12 Are tables and chairs at a convenient height and location so that individuals can access and use them comfortably?

___Yes
___No

Comments:

2.13 Does the physical environment support a variety of individual goals and needs (e.g., does the setting provide indoor and outdoor gathering spaces; does the setting provide for larger group activities as well as solitary activities; does the setting provide for stimulating as well as calming activities)?

___Yes
___No

Comments:

2.14 Does the dining area afford dignity to diners, including by not requiring individuals to wear bibs and by not using disposable cutlery, plates and cups?

___Yes
___No

Comments:

2.15 Does the setting post in a prominent location or otherwise furnish information on the provider's policies concerning individual rights?

___Yes
___No

Comments:

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Section 3- INTEGRATION WITH THE COMMUNITY

All questions are required unless noted otherwise.

Instructions to be Read to Member

I am here on behalf of the State because we're interested in learning about your experience at -PROVIDER NAME-. We especially want to make certain that you are. treated with respect and have the same rights and freedom as other people who live elsewhere in this community.

I am going to ask questions that you can answer yes or no. You can explain your answer if you want to share more Information. It should take about 30 minutes. *(Note to assessor:* Members *also can answer "Don't Know" but should not be prompted with this option.)*

What you tell me will be kept confidential and will not be shared with **-PROVIDER NAME-.** We will combine your answers with the answers of other people around Vermont.

Nothing you tell me will affect your eligibility for services. The information will only be used to improve services for people like you around the State.

Do you have any questions before we begin? If not, is it OK to start?

First, I have some questions about whether you have opportunities to do things In the community and here at -PROVIDER NAME-.

3. 1 If you want to, can you go out into the community during the day? (Interviewer prompt: "For example, are you able to visit friends, go shopping or to a movie?")

___ Yes
___ No
___Don't Know

Comments:

3.2 Does -**PROVIDER NAME-** tell you about things to do, like shopping, attending church, eating out or going to concerts, parades, movies or fairs?

___ Yes
___ No
___Don't Know

Comments:

3.3 In the past month, have you gone shopping, to church or out to eat with family and friends? *(This does* not *include going to a job.)*

___ Yes
___ No
___Don't Know

Comments:

3.4 Have you been given information about available transportation? *(Interviewer prompt: For example, has* anyone *shown you how* to use the *bus or call a taxi)*

___ Yes
___ No
___Don't Know

Comments:

3.5 (If member uses a wheelchair, ask. Otherwise enter NIA): Have you been given information about wheelchair accessible transportation?

___ Yes
___ No
___Don't Know
___N/A

Comments:

3.6 If you want to, can you have a paid job? *(Interviewer prompt: For example,* is *there someone* to *help you look for or* get *ready for job, if you want one?)*

___ Yes
___ No
___Don't Know

Comments:

3.7 Have you told **·PROVIDER NAME**- that you wanted a job?

___ Yes
___ No
___Don't Know

Comments:

3.8 Do you have a paid job?

___ Yes
___ No
___Don't Know

Comments:

3.9 If you want to, can you volunteer in the community? *(Interiewer Prompt: For example, is there someone to help you look for volunteer work, if you asked?)*

___ Yes
___ No
___Don't Know

Comments:

3.10 Have you told **-PROVIDER NAME-** that you wanted to volunteer somewhere?

___ Yes
___ No
___Don't Know

Comments:

3.11 Are you volunteering somewhere?

___ Yes
___ No
___Don't Know

Comments:

3.12 Can you go anywhere you want inside and outside this house?

___ Yes
___ No
___Don't Know

Comments:

3.13 Can people come and visit you anytime?

___ Yes
___ No
___Don't Know

Comments:

3.14 Are you allowed to have guests stay overnight?

___ Yes
___ No
___Don't Know

Comments:

3.15 Do you have access to your money? *(Interviewer prompt: For example, can you buy things you need and make choices about how to spend your money?)*

___ Yes
___ No
___Don't Know

Comments:

3.16 Were you offered help setting up a savings or checking account that you control? *(Interviewer prompt: For example,* has *anyone* ever *helped you open a bank account?)*

___ Yes
___ No
___Don't Know

Comments:

3.17 Do you have a savings or checking account that you control? *(Interviewer prompt: For example, does anyone else have to sign your bank slips?)*

___ Yes
___ No
___Don't Know

Comments:

3.18 Do you have a choice in what services and supports you receive? *(Interviewer Prompt: For example, if you wanted* more *time* out *of the house or wanted to talk to a* counselor, *can* you *ask* for *that support?)*

___ Yes
___ No
___Don't Know

Comments:

3.19 Do you have a choice in who provides your services and supports? *(Interviewer Prompt: For example, if you wanted a different helper or wanted another place* to *live, do people* listen *to you?)*

___ Yes
___ No
___Don't Know

Comments:

Section 4- PRIVACY, DIGNITY & RESPECT

All questions are required unless noted otherwise.

Interviewer Prompt: "Next, I have some questions about how you're treated here at **-PROVIDER NAME-** and whether your privacy is respected."

4.1 Can you be alone if you want to be during the day? *(Interviewer prompt: For example, can you* have *a conversation* with *a friend in private? Do* you *have time without staff listening or watching?)*

___ Yes
___ No
___Don't Know

Comments:

4.2 Do the staff members who support you while you are working or participating in an activity treat you the way you want to be treated? */Interviewer prompt: For example, do helpers and staff listen to you?)*

___ Yes
___ No
___Don't Know

Comments:

4.3 Do you need help getting dressed?

___ Yes
___ No
___Don't Know

Comments:

4.4 Do you pick out your *own* clothes?

___ Yes
___ No
___Don't Know

Comments:

4.5 Does -**PROVIDER NAME**- give you a safe place to store your personal belongings? *(Interviewer Prompt: Do you have a Sate pflace to keep* your *stuff at home?)*

___ Yes
___ No
___Don't Know

Comments:

- ○ Yes
- ○ No
- ○ D/K

Comment:

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Full Name	Primary Phone	Town of Residence	County
Agency: Barre Project Independence			
[redacted]			Orange
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington

Agency: Barre Project Independence: 8 unduplicated consumers

Agency: Bennington Project Independence			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Out Of State
[redacted]			Bennington
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bennington Project Independence			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
Agency: Bennington Project Independence: 38 unduplicated consumers			
Agency: Care Partners Adult Day Center			
[redacted]			Grand Isle
[redacted]			Grand Isle
[redacted]			Franklin
[redacted]			Grand Isle
[redacted]			Grand Isle
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Grand Isle
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
Agency: Care Partners Adult Day Center: 18 unduplicated consumers			
Agency: Elderly Services Inc.			
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Agency: Elderly Services Inc.

Full Name	Primary Phone	Town of Residence	County
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Rutland
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison
[redacted]	[redacted]	[redacted]	Addison

Agency: Elderly Services Inc.: 46 unduplicated consumers

Agency: Green Mt. Adult Day Orleans County (Newport)

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Full Name	Primary Phone	Town of Residence	County
Agency: Green Mt. Adult Day Orleans County (Newport)			
[redacted]			Orleans
[redacted]			Orleans

Agency: Green Mt. Adult Day Orleans County (Newport): 2 unduplicated consumers

Agency: Interage Adult Day (Rutland)			
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland

Agency: Interage Adult Day (Rutland): 17 unduplicated consumers

Agency: Lamoille Day Health Services (Out & About)			
[redacted]			Caledonia
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Caledonia
[redacted]			Lamoille
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Caledonia
[redacted]			Lamoille
[redacted]			Lamoille

Agency: Lamoille Day Health Services (Out & About): 14 unduplicated consumers

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Full Name	Primary Phone	Town of Residence	County
Agency: Oxbow Senior Independence Program			
[redacted]			Orange
[redacted]			Orange
[redacted]			Caledonia
[redacted]			Orange

Agency: Oxbow Senior Independence Program: 4 unduplicated consumers

Agency: Riverside Life Enrichment Center			
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia

Agency: Riverside Life Enrichment Center: 15 unduplicated consumers

Agency: Springfield Area ADS			
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Full Name	Primary Phone	Town of Residence	County
Agency: Springfield Area ADS: 15 unduplicated consumers			
Agency: The Gathering Place			
[redacted]			Bennington
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
Agency: The Gathering Place: 13 unduplicated consumers			
Agency: The Meeting Place			
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
Agency: The Meeting Place: 6 unduplicated consumers			
Agency: VNA Adult Day (Essex Junction)			
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey CFC Adult Day Services

Active care plans sorted by provider

Full Name	Primary Phone	Town of Residence	County
Agency: VNA Adult Day (Essex Junction)			
■	[redacted]		Chittenden
■			Chittenden
Agency: VNA Adult Day (Essex Junction): 15 unduplicated consumers			
Agency: VNA Adult Day (Prim)			
■	[redacted]		Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
Agency: VNA Adult Day (Prim): 16 unduplicated consumers			
Agency: VNA Adult Day (So Burlington)			
■	[redacted]		Chittenden
■			Addison
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
■			Chittenden
Agency: VNA Adult Day (So Burlington): 7 unduplicated consumers			

Summary:	234 consumers

Total : $196,756.39

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Addison County Home Health Agency			
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Addison County Home Health Agency			
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison
[redacted]			Addison

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Addison County Home Health Agency			
[redacted]			Addison

Agency: Addison County Home Health Agency: 83 unduplicated consumers

Agency: Bayada Professional Nurses Service Inc			
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Windham
[redacted]			Windsor
[redacted]			Chittenden
[redacted]			Windham
[redacted]			Bennington
[redacted]			Orleans
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Grand Isle
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Windham
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Franklin
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Addison
[redacted]			Windsor
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bayada Professional Nurses Service Inc			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Addison
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Windham
[redacted]			Rutland
[redacted]			Addison
[redacted]			Windsor
[redacted]			Bennington
[redacted]			Windham
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Franklin
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Windham
[redacted]			Windham
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Orange
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Washington
[redacted]			Windham
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Windham
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bayada Professional Nurses Service Inc			
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Addison
[redacted]			Windham
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Bennington
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Windham
[redacted]			Bennington
[redacted]			Orleans
[redacted]			Windham
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Windham
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Windsor
[redacted]			Windham
[redacted]			Orleans
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Franklin
[redacted]			Windham
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Orange
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bayada Professional Nurses Service Inc			
[redacted]			Windham
[redacted]			Chittenden
[redacted]			Windsor
[redacted]			Orleans
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Washington
[redacted]			Windsor
[redacted]			Orleans
[redacted]			Franklin
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Rutland
[redacted]			Addison
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Franklin
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Windham
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Orleans
[redacted]			Bennington
[redacted]			Franklin
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bayada Professional Nurses Service Inc			
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Franklin
[redacted]			Rutland
[redacted]			Windham
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Washington
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Washington
[redacted]			Chittenden
[redacted]			Washington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Windham
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Windham
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Orleans
[redacted]			Out Of State
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Windham

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bayada Professional Nurses Service Inc			
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Windham
[redacted]			Windham
[redacted]			Rutland
[redacted]			Washington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Windsor
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Windham
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Windham
[redacted]			Windham
[redacted]			Rutland
[redacted]			Franklin
[redacted]			Bennington
[redacted]			Addison
[redacted]			Windham
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Windsor

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Bayada Professional Nurses Service Inc			
[redacted]			Rutland
[redacted]			Franklin
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Windham
[redacted]			Windsor
[redacted]			Washington
[redacted]			Bennington
[redacted]			Grand Isle
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Orleans
[redacted]			Chittenden
[redacted]			Windham
[redacted]			Windham
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Windham
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Bennington
[redacted]			Windham
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Windham
[redacted]			Windham
[redacted]			Rutland
[redacted]			Windham
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Bayada Professional Nurses Service Inc: 281 unduplicated consumers

Agency: Caledonia Home Health

Full Name	Primary Phone	Town of Residence	County
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Caledonia Home Health			
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
Agency: Caledonia Home Health: 66 unduplicated consumers			
Agency: Central Vermont Council On Aging			
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Addison
[redacted]			Lamoille
[redacted]			Washington
[redacted]			Orange
[redacted]			Orange
[redacted]			Orange
[redacted]			Lamoille
[redacted]			Windsor

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Central Vermont Council On Aging			
[redacted]			Washington
[redacted]			Lamoille
[redacted]			Washington
[redacted]			Orange
[redacted]			Windsor
[redacted]			Washington
[redacted]			Windsor
[redacted]			Orange
[redacted]			Washington
[redacted]			Lamoille
[redacted]			Orange
[redacted]			Orange
[redacted]			Windsor
[redacted]			Orange
[redacted]			Rutland
[redacted]			Orange
[redacted]			Windsor
[redacted]			Orange
[redacted]			Orange
[redacted]			Lamoille
[redacted]			Washington
[redacted]			Lamoille
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Windsor
[redacted]			Orange
[redacted]			Orange
[redacted]			Windsor
[redacted]			Addison
[redacted]			Washington
[redacted]			Washington
[redacted]			Lamoille
[redacted]			Windsor
[redacted]			Lamoille
[redacted]			Windsor
[redacted]			Washington
[redacted]			Washington
[redacted]			Windsor
[redacted]			Rutland
[redacted]			Lamoille

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Central Vermont Council On Aging			
[redacted]			Lamoille
[redacted]			Orange
[redacted]			Orange
[redacted]			Windsor
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Addison
[redacted]			Rutland
[redacted]			Windsor
[redacted]			Washington
[redacted]			Washington
[redacted]			Lamoille
[redacted]			Lamoille
[redacted]			Addison
[redacted]			Washington
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Lamoille
[redacted]			Windsor
[redacted]			Orange
[redacted]			Windsor
[redacted]			Washington
[redacted]			Orange
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Addison
[redacted]			Windsor
[redacted]			Washington
[redacted]			Orange
[redacted]			Orange
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Orange
[redacted]			Orange
Agency: Central Vermont Council On Aging: 85 unduplicated consumers			
Agency: Central VT Home Health Agency & Hospice			
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Orange

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Central VT Home Health Agency & Hospice			
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Orange
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington
[redacted]			Washington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Central VT Home Health Agency & Hospice			
[redacted]			Washington
[redacted]			Washington

Agency: Central VT Home Health Agency & Hospice: 47 unduplicated consumers

Agency: Champlain Valley Agency on Aging

[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Grand Isle
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Grand Isle
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Grand Isle
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging			
[redacted]			Franklin
[redacted]			Addison
[redacted]			Franklin
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Grand Isle
[redacted]			Franklin
[redacted]			Addison
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Grand Isle

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging			
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Grand Isle
[redacted]			Addison
[redacted]			Addison
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging			
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Addison
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging			
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Rutland
[redacted]			Franklin
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging			
[redacted]			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Franklin
			Chittenden
			Chittenden
			Chittenden
			Addison
			Franklin
			Addison
			Franklin
			Addison
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Addison
			Grand Isle
			Rutland
			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging			
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Addison
[redacted]			Chittenden
[redacted]			Franklin

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Champlain Valley Agency on Aging: 280 unduplicated consumers			
Agency: Council on Aging for Southeastern VT			
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Bennington
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Bennington
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windham
[redacted]		[redacted]	Windsor

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Council on Aging for Southeastern VT			
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Rutland
[redacted]			Windham
[redacted]			Bennington
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Council on Aging for Southeastern VT			
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Bennington
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham

Agency: Council on Aging for Southeastern VT: 111 unduplicated consumers

Agency: Franklin County Home Health & Hospice			
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Chittenden
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Franklin County Home Health & Hospice			
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin
[redacted]			Franklin

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Franklin County Home Health & Hospice

Full Name	Primary Phone	Town of Residence	County
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin
■ [redacted]			Franklin

Agency: Franklin County Home Health & Hospice: 78 unduplicated consumers

Agency: Lamoille Home Health Agency & Hospice

Full Name	Primary Phone	Town of Residence	County
■ [redacted]			Lamoille
■ [redacted]			Lamoille
■ [redacted]			Lamoille
■ [redacted]			Lamoille

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Lamoille Home Health Agency & Hospice

	Full Name	Primary Phone	Town of Residence	County
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille
■	[redacted]			Lamoille

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Lamoille Home Health Agency & Hospice: 44 unduplicated consumers			
Agency: Manchester Health Services, Inc.			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
Agency: Manchester Health Services, Inc.: 14 unduplicated consumers			
Agency: Northeastern Vermont Area Agency on Aging			
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Essex

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Northeastern Vermont Area Agency on Aging			
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Essex
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Essex
[redacted]			Orleans

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Northeastern Vermont Area Agency on Aging			
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Essex
[redacted]			Essex
[redacted]			Caledonia
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Caledonia
[redacted]			Orleans

Agency: Northeastern Vermont Area Agency on Aging: 88 unduplicated consumers

Agency: Orleans-Essex VNA Association & Hospice, Inc.			
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Orleans-Essex VNA Association & Hospice, Inc.

Full Name	Primary Phone	Town of Residence	County
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Essex
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Essex
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Orleans-Essex VNA Association & Hospice, Inc.			
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Essex
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Essex
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
[redacted]			Orleans
Agency: Orleans-Essex VNA Association & Hospice, Inc.: 76 unduplicated consumers			
Agency: Rutland Area VNA Hospice			
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Rutland Area VNA Hospice			
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Lamoille
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Rutland Area VNA Hospice

Full Name	Primary Phone	Town of Residence	County
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Rutland Area VNA Hospice			
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Out Of State
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington

Agency: Rutland Area VNA Hospice: 126 unduplicated consumers

Agency: Southwestern Vermont Council on Aging			
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Southwestern Vermont Council on Aging			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Southwestern Vermont Council on Aging			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Southwestern Vermont Council on Aging			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Southwestern Vermont Council on Aging			
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Southwestern Vermont Council on Aging			
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Southwestern Vermont Council on Aging			
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Rutland
[redacted]			Rutland
[redacted]			Bennington
[redacted]			Bennington

Agency: Southwestern Vermont Council on Aging: 223 unduplicated consumers

Agency: Visiting Nurse Alliance of VT & New Hampshire			
[redacted]			Windsor
[redacted]			Windham
[redacted]			Orange
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Orange
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Orange
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Orange
[redacted]			Windsor

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Visiting Nurse Alliance of VT & New Hampshire			
■	[redacted]		Windham
■			Windham
■			Windsor
■			Windham
■			Windsor
■			Orange
■			Windsor
■			Windsor
■			Orange
■			Orange
■			Windsor
■			Windsor
■			Windsor
■			Windsor
■			Windsor
■			Windsor
■			Windsor
■			Windsor
■			Orange
■			Windsor
■			Windsor
■			Windham
■			Windsor
■			Windsor
■			Windham
■	[redacted]		Windsor
■			Windsor
■			Windsor
■			Windsor
■			Windham
■			Orange
■			Orange
■			Windsor
■			Windsor
■			Windham
■			Windsor
■			Windham
■			Windham
■			Orange

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Visiting Nurse Alliance of VT & New Hampshire			
[redacted]			Out Of State
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Bennington
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windham
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham
[redacted]			Orange
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windsor
[redacted]			Windham
[redacted]			Windsor
[redacted]			Windham

Agency: Visiting Nurse Alliance of VT & New Hampshire: 102 unduplicated consumers

Agency: Visiting Nurse Association, Chitt & Grand Isle			
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Visiting Nurse Association, Chitt & Grand Isle

Full Name	Primary Phone	Town of Residence	County
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Windham
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Visiting Nurse Association, Chitt & Grand Isle			
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Visiting Nurse Association, Chitt & Grand Isle

Full Name	Primary Phone	Town of Residence	County
[redacted]			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
[redacted]			Grand Isle
			Grand Isle
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden
			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Agency: Visiting Nurse Association, Chitt & Grand Isle

Full Name	Primary Phone	Town of Residence	County
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Visiting Nurse Association, Chitt & Grand Isle			
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Grand Isle
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden
[redacted]			Chittenden

Agency: Visiting Nurse Association, Chitt & Grand Isle: 202 unduplicated consumers

Full Name	Primary Phone	Town of Residence	County
Agency: VNA & Hospice of Southwestern Vermont Health Care			
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington
[redacted]			Bennington

Care Plan Monitoring Report

- HCBS Validation Survey Case Management Services sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: VNA & Hospice of Southwestern Vermont Health Care			
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Windham
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Out Of State
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington
[redacted]	[redacted]	[redacted]	Bennington

Agency: VNA & Hospice of Southwestern Vermont Health Care: 32 unduplicated consumers

Summary:	1,439 consumers

Total : 1,798,682.53

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Thursday, November 16, 2017 10:32 AM
To: Skaflestad, Shawn
Cc: Courcelle, Andre
Subject: CFC HCBS Final Alignment Report w fixed links 11.16.17.docx
Attachments: CFC HCBS Final Alignment Report w fixed links 11.16.17.docx

Here is the updated report with new hyperlinks. Note that a couple of those items are no longer available as they have been modified since the original report was written. I noted that and added the new links.

Megan

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Thursday, November 16, 2017 10:32 AM
To: Skaflestad, Shawn
Cc: Courcelle, Andre
Subject: CFC HCBS Final Alignment Report w fixed links 11.16.17.docx
Attachments: CFC HCBS Final Alignment Report w fixed links 11.16.17.docx

Here is the updated report with new hyperlinks. Note that a couple of those items are no longer available as they have been modified since the original report was written. I noted that and added the new links.

Megan

Schurr, Stuart

From: Hickman, Selina
Sent: Friday, June 23, 2017 11:36 AM
To: Schenck, Tom M.(CMS/CMCHO); Skaflestad, Shawn
Cc: Hutt, Monica
Subject: RE: Follow up question on CFC HHA/AAAs

Great- thank you, Tom!

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
(802) 585-9934

From: Schenck, Tom M.(CMS/CMCHO) [mailto:Tom.Schenck@cms.hhs.gov]
Sent: Friday, June 23, 2017 11:34 AM
To: Hickman, Selina <Selina.Hickman@vermont.gov>; Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Thanks, Selina! Glad to have you back! I've passed this along to our HCBS SMEs and I'll be in touch once I know next steps.

From: Hickman, Selina [mailto:Selina.Hickman@vermont.gov]
Sent: Friday, June 23, 2017 10:58 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Schenck, Tom M.(CMS/CMCHO) <Tom.Schenck@cms.hhs.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Hi Tom,
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I hope you are well!

Best,

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
(802) 585-9934

From: Skaflestad, Shawn
Sent: Friday, May 05, 2017 10:48 AM
To: Schenck, Tom M.(CMS/CMCHO) <Tom.Schenck@cms.hhs.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

Tom – thanks for the follow up question. I will confer with the appropriate folks here at the agency and be back in touch.

Best,

Shawn

Shawn E. Skaflestad, Ph.D.
Quality Improvement Manager
Agency of Human Services
280 State Drive Center Building
3rd Floor – E310-1
Waterbury, VT 05671-1000
Office: (802) 241-0961
Cell Phone: (802) 585-4410
Fax: 802-241-0450

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(Access through Internet Explorer 10, Firefox, or Google Chrome).

From: Schenck, Tom M.(CMS/CMCHO) [mailto:Tom.Schenck@cms.hhs.gov]
Sent: Thursday, May 04, 2017 5:32 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Cc: Hickman, Selina <Selina.Hickman@vermont.gov>
Subject: Follow up question on CFC HHA/AAAs

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I'm following up on this memo from last summer regarding the geographically designated HHAs that CMS is reviewing. We're wondering about item 1a on page 6. Could you elaborate on the statement regarding a potential determination that the HHAs/AAAs are the only qualified entities to provide both direct care and case management services. Specifically, does VT believe that to be the case statewide or only in certain geographic entities? Any further information that could help us consider a potential designation would be helpful.

Thanks,

Tom Schenck
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
(617) 565-1325

Conflict Free Case Management and Vermont Community Mental Health Services

This policy brief seeks to illustrate how the conflict-free case management exception found at 42 CFR § 441.301 may be applied to the State of Vermont Community Mental Health system through examination of Vermont's 1115 Demonstration, State statutes and Administrative rules. Specifically, this brief seeks to demonstrate that "[...]the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS."

1. Global Commitment to Health 1115 Demonstration Waiver

Through its Demonstration, Vermont employs a managed care-like delivery system in which a unit of state government operates largely as if it were a non-risk prepaid inpatient health plan. One component of the managed care-like delivery system is establishing a network of providers that is adequate to meet the needs of individuals served. This construct is reflected in the section 1902(a)(23)(A) "freedom of choice" waiver authority provided through the Demonstration and further detailed at STC 27 "Limitation of Freedom of Choice." This authority permits the State to use specialized provider networks for special health programs including CRT and SED (also known as Enhanced Family Treatment (EFT)). Individuals that are eligible for Medicaid, but who do not meet eligibility criteria for CRT and SED, and who require medically necessary mental health services under the Medicaid State Plan may seek such care from any qualified provider enrolled in the Vermont Medicaid program and is not restricted to the specialized provider network for the special health programs.

2. Vermont Statutes

Vermont State statute at 18 V.S.A. § 8907 "Designation of agencies to provide mental health and developmental disability services" further establishes and requires designation of specific agencies as providers of community mental health services. Specifically, the statute requires:

> "(a) Except as otherwise provided in this chapter, the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living shall, within the limits of funds designated by the Legislature for this purpose, ensure that community services to persons with a mental condition or psychiatric disability and persons with a developmental disability throughout the State are provided through designated community mental health agencies. The Commissioners shall designate public or private nonprofit agencies to provide or arrange for the provision of these services."

The statute further establishes that the designated agencies must provide or otherwise arrange for all required services within their jurisdiction and for individuals who "reside within the geographic area served by the agency."

Vermont State statute at 18 V.S.A. § 8912 establishes the only instance in which services may be provided by non-Designated Agencies (also known as "Specialized Service Agencies"). This may occur in the instance that services "[...] are not available from designated community mental health agencies."

3. Administrative Rules

Agency Administrative rules on Agency Designation echo and further clarify the Vermont State statutes. Rules at section 2 establish that the Commissioner "[...] shall designate one agency in each geographic area of the state to assure that people in local communities receive services and supports, consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, regulations promulgated by DDMHS, the goals of Vermont for its citizens, the goals of the citizens themselves, and other policies, plans, regulations, and laws."

Minimum qualifications for these providers are established at section 4 of the same rules.

Section 5 describes the conditions under which a Specialized Service Agency may be established and reiterates that "The Commissioner may enter into a new Specialized Services contract only if the Commissioner determines that these services are not available from or cannot be developed by a Designated Agency within a reasonable timeframe and in the manner required by the department."

Discussion

As a result of the above policy environment, Vermont's Community Mental Health System of Care is currently comprised of ten (10) Designated Agencies operating in distinct geographic regions of the state and two (2) Specialized Services Agencies. These Designated and Specialized Service Agencies, as authorized by federal and state authorities, are the only qualified and willing providers of case management services for individuals they serve through the HCBS-like CRT and EFT programs.

The Vermont statutes have driven the comprehensive service capacities of the existing provider network and current system efficiencies. In addition to the citations above, Vermont has embedded significant protections and safeguards for individuals and families served, as follows:

- ✓ In 2001, Administrative Rules for Agency Designation were promulgated in Vermont requiring consumer and family majority representation in modifications to service delivery programs and transparency in system oversight at both a regional level, as well as, state level for SPMI adults, SED children and their families, and the developmentally disabled.

- ✓ At the onset of its 1115B waiver authority for SPMI adults in 1999, a grievance and appeals processes was put in place in consideration of the limitation of Freedom of Choice and continues through the most recent renewal STC 27 to assure ongoing protections and safeguards for individuals served by the Designated Agency system.

- ✓ These same grievance and appeals safeguards are also codified in the Administrative Rules for SED children and families and developmentally disabled individuals served.

- ✓ Vermont also has strong advocacy networks operating statewide that are supported by state resources in their mission to assist the population groups most frequently served by the Designated Agency Network. These organizations are knowledgeable advocates and represent individual consumers and their collective voices when access or unmet service

needs are identified and should be addressed through flexibilities of the State's 1115 waiver and requirements outlined in Administrative Rules.

Vermont believes that its existing system infrastructure meets the intent and affords the safeguards conceptualized by organizationally separating case management service from organizations providing other, and often multiple types of, needed services to vulnerable populations. As a small rural state and with mechanisms currently in place, the creation and support of additional organizations of specialized service capacity would not be cost effective in administration or necessarily efficient for the individual or families receiving services. Vermont believes that it can demonstrate through its inclusion of persons served and multiple existing safeguards, oversight activities, and feedback and reporting mechanisms that it meets the spirit and intent of the HCBS Rule for conflict free case management.

Schurr, Stuart

From:	Hickman, Selina
Sent:	Friday, June 23, 2017 10:58 AM
To:	Skaflestad, Shawn; Schenck, Tom M.(CMS/CMCHO)
Cc:	Hutt, Monica
Subject:	RE: Follow up question on CFC HHA/AAAs
Attachments:	HHA_AAA designation inquiry_062317.docx

Hi Tom,
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Best,

Selina

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
Vermont Agency of Human Services
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Thanks,

Tom Schenck
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
(617) 565-1325

Vermont Response to CMS Inquiry
June 23, 2017

CMS Requests from 05/04/16

I'm following up on this memo from last summer regarding the geographically designated HHAs that CMS is reviewing. We're wondering about item 1a on page 6. Could you elaborate on the statement regarding a potential determination that the HHAs/AAAs are the only qualified entities to provide both direct care and case management services. Specifically, does VT believe that to be the case statewide or only in certain geographic entities? Any further information that could help us consider a potential designation would be helpful.

Vermont Response:

The answer to your question is Yes- HHAs/AAAs are the only qualified entities to provide both direct care and case management services statewide. HHAs are designated in Vermont state statute and AAAs are designated by the State and are established in accordance with the Older Americans Act. When providing case management, both entities must follow the same Case Management Standards and Certification Procedures for Older Americans Act and Choices for Care. This unique arrangement results in the only willing and qualified entity to perform assessments of functional need and develop person-centered service plans also providing HCBS.

VERMONT

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.ahs.state.vt.us

Selina H. Hickman
Director of Health Care Operations, Compliance, & Improvement
[phone] 802-241-0422
[fax] 802-241-0451

Dear Ms. Kayala,

We are writing to invite your review of Vermont's current processes and standards for service authorization and person-centered planning in the Choices for Care program. We also invite your feedback on how to best achieve alignment between differing federal and state standards as Vermont plans for greater integration with Patient Centered Medical Homes, Specialized Health Homes and Accountable Care Organizations for Choices for Care. Attached please find a summary brief outlining our current program operations, current and proposed planning efforts and timeline.

We understand that federal conflict of interest rules established for 1915 (c) and other similar home and community based service (HCBS) programs limit the ability of a single provider to offer both case management and direct services. Vermont shares the goal of ensuring participant access to effective, high quality, conflict free case management. However, we are concerned that implementation could limit participants' rights to choose their providers, inhibit participants' ability to access necessary care, and disrupt our current efforts at integrating primary care with our managed long term services and supports (MLTSS) including HCBS values and principles.

Vermont seeks CMS assistance in developing a policy strategy that aligns HCBS requirements with Choices for Care policies and operations in order to achieve the following objectives:

- Maintain Vermont's commitment to individual consumer choice and control as a foundational concept of the successful Choices for Care program
- Strengthen necessary protections to ensure that care planning activities are not influenced by a providers' other service delivery roles
- Maintain and improve access to person-centered planning statewide
- Support ongoing quality improvement in care delivery
- Sustain Vermont's rural service delivery system
- Maximize use of public resources for care delivery through administrative efficiencies and minimize budget shortfalls
- Align with Vermont's integration of LTSS with primary care, preventive care, mental health care, and substance use treatment in Vermont health reform efforts, including efforts to achieve greater consistency across public and private payers.

Vermont seeks to work with CMS to align these objectives and mitigate any unintended consequences in addressing conflicts of interest, including:

- Restriction of individual participant choice
- Erosion of access to care due to:
    - Loss of comprehensive providers and specialized expertise

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  - Diminished availability of services resulting from providers discontinuing either case management or direct care services
  - Disruption of case management services including slower access to HCBS and poorer quality of case management services due to the limited availability of qualified case management staff, during any transition period
- Diversion of funds away from direct services to support a new administrative structure for the provision of case management-only services.
- Increased program costs resulting from different yet overlapping service definitions for case management, care coordination, service coordination and authorization, medical social work and person-centered planning across multiple programs and settings

We seek your concurrence on our proposed planning process and timeline. The process is designed to allow for meaningful stakeholder input into a delivery system transformation that promotes the integration of primary care with our MLTSS and consistency in regulatory policies across public and private payers.

We are optimistic that Vermont and CMS can partner to develop a solution that continues to promote individual consumer choice and control, ensures that services are accessible and sustainable, promotes effective and cost-efficient integrated service delivery, and provides appropriate safeguards against conflicts of interest.

We look forward to a discussion following your review of the attached materials. Please don't hesitate to contact either of us (Selina Hickman at 802-585-9934 or Commissioner Hutt at 802-241-0360) for additional information and/or questions.

Sincerely,

Selina Hickman,
Director of Healthcare Operations, Compliance and Improvement
Agency of Human Services, Secretary's Office

Monica Hutt,
Commissioner, Department of Disabilities, Aging and Independent Living
Agency of Human Services

Cc: Megan Tierney-Ward, Director Adult Services Division
Sara Lane, Director Choices for Care Program
Steven Costantino, Medicaid Director
Dina Payne, CMCS State Demonstrations, VT 1115 Project Officer

Encl: Choices for Care Program Summary and HCBS/Medicaid Planning Timeline

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Choices for Care Program Summary and Proposed Planning to Strengthen Conflict of Interest Protections: July 2016

This document provides a summary of the Choices for Care program under Vermont's Section 1115 public managed care demonstration, Global Commitment to Health. Section I provides an overview of the Choices for Care program including participants, providers, case examples and outcomes. Section II provides an overview of Vermont's proposed planning process and goals in establishing greater integration between primary care, mental health and managed long term services and supports (MLTSS) across public and private payers. Section III provides an overview of our planning timelines and specific action steps.

I. Choices for Care Program Overview

Program and Participants

In 2005 Vermont opted not to continue several former 1915 (c) waivers for persons with physical disabilities and frail elders, but rather to seek Section 1115 approval to implement a larger reform based on equalizing the entitlement and creating a seamless system of care between nursing facility and an array of cost effective community based care options. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full consumer choice in when, where and from whom to receive services.

Persons who meet skilled nursing facility level of care (known as Highest and High Needs Groups) are eligible to receive an array of services within the CFC benefit package. CFC also includes a limited benefit package for Medicaid State Plan and non-Medicaid participants who do not meet, but may be at risk of, skilled nursing facility placement; this is known as the Moderate Needs Group. The Choices for Care program is managed by the Department of Disabilities, Aging and Independent Living (DAIL) as part of Vermont's Public Managed Care model and as designated by the Agency of Human Services (AHS).

Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules that are in the High or Highest Needs Group (i.e., meeting nursing facility level of care). As of January 2016, 1,826 persons in the Highest and High Needs Group chose skilled nursing facility care, 1,605 persons chose home based supports, and 487 persons chose community residential care (PNMI). As of January 2016, 1,492 persons received limited in home benefits as part of the Moderate Needs Group. The median age of CFC participants is 83 and the median length of stay in the program is 1.6 years, with most program terminations due to death of the recipient.

Providers, Case Management Certifications and Protections

Vermont is a small rural state. The State maintains a geographically designated Home Health Agency (HHA) system. Twelve HHAs are recognized in State law/regulation and are required to

serve Choices for Care program participants in their region. One agency is recognized for statewide delivery of services.

In addition, through the Older Americans Act (OAA), DAIL designates five regionally based Area Agencies on Aging responsible for statewide coverage of OAA services. These AAA organizations are also authorized to provide HCBS companion services under CFC. Vermont has received federal approval under the Older Americans Act State Plan to allow AAAs to provide both case management and direct care when needed to assure access to necessary services for participants.

The full array of CFC services is delivered through the following providers:

- 75 Assisted Living Residences and Residential Care Homes (PNMI)
- 37 Skilled Nursing Facilities
- 12 geographically designated, non-profit HHAs
- 1 statewide, for-profit HHA
- 5 Area Agencies on Aging
- 14 Adult Day Providers
- 15 Specialized non-profit agencies with Developmental Disability, Traumatic Brain Injury and Mental Health expertise in creating highly individualized Adult Family Care placements for persons with complex needs in the community
- 1 Administrative Services Organization for persons who self-manage services

Given the rural nature of the State and its small size, no Vermont provider only offers case management services. Due to Vermont's labor market, small population and economic drivers, developing additional provider types has not been economically viable or supported by legislative action. It is not unusual to have multiple community agencies involved with any given CFC participant.

> *[redacted] lives in his family home; his LTSS supports through the Choices for Care program have included 8 months of Skilled Nursing Facility Care. He currently lives in his family home with his wife. [redacted] receives 40 hours a week of caregiver support through a combination of his daughter's support (unpaid) and caregivers from the Home Health Agency. He also receives companion services through the Area Agency on Aging. His case management choice is the Home Health Agency. Additional supports have been provided through volunteer time from other family and friends. Home modifications for wheelchair access have been supported through the Veterans Administration and volunteer labor. Medical follow-up is provided through his primary care physician in the community.*

The Vermont Department of Disabilities Aging and Independent Living (DAIL) conducts periodic on-site quality reviews and certifications of providers designated to provide case management services in the CFC program. Both HHAs and AAAs undergo certification. In the event that a consumer chooses a case manager who is also affiliated with the provision of one or more services in their care plan, Vermont standards and policies require that providers must have policies in place to address conflict of interest; individual treatment team conflicts must be

considered and mitigated. In several regions, HHAs have chosen to create separate entities with differing supervisory structures to preserve a distinction between case management and direct care staff. Vermont standards are currently under review as part of our HCBS Quality Strategy and will be enhanced based on stakeholder input. A link to our current standards is available at Case Management Standards.

All Choices for Care participants have access to the State Long-Term Care Ombudsman to help resolve provider complaints, regardless of whether they receive their services in a facility or home and community setting. In addition, the State maintains a grievance and appeal system and supports Aging and Disability Resource Centers (ADRCs) in each region.

Services and Person-Centered Planning

All individuals applying for Highest and High needs services meet with a State of Vermont Long Term Care Clinical Coordinator (LTCCC) Nurse for an initial assessment of clinical eligibility and physical functional needs. State staff also are responsible for the authorization of any subsequent change of service once enrolled. Initial meetings include a discussion of service options, providers and a referral for independent options counseling as needed. Consumers have equal access to an array of traditional State Plan services, including skilled nursing facilities, residential care in a PNMI (private non-medical institution) facility, in home and community based options such as companion care, respite and other rehabilitative therapies as well as flexible options for self-managing some or all of their care providers. Once enrolled in the CFC program, a consumer may choose whether to receive on-going case management services from a HHA or an AAA. Thus final CFC service packages are based on clinical profile, support needs, State Plan and unique section 1115 demonstration authorities and services.

> [redacted] *was diagnosed with spinal stenosis years ago. As time passed, it became increasingly debilitating, her in home support needs increased and she lost use of her arms. Following surgery and 5 months of nursing facility services she began to regain limited use.* [redacted] *is 86 and now lives in her own family home; she currently has a combination of surrogate/self-managed in home support workers and Home Health Agency Case Management.*

The LTCCC's are also responsible for utilization review of any request for home based, Adult Family Care and Enhanced Residential Care services and anytime there is an initial assessment reassessment or a change in significant function prior to the annual reassessment date.

Unlike traditional 1915 (c) programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, acute rehabilitation facilities, home care and adult family care in any given eligibility period. All participants meet skilled nursing facility level of care and have complex medical profiles, support needs and/or dementia care needs. As such, there is a mix of providers involved in any given service plan. Hospice and end of life care at home are not unusual in the program and services may change rapidly over the course of several months.

> [redacted] *is diabetic with multiple complications of this disease including proliferative diabetic retinopathy of both eyes and renal failure. He undergoes hemodialysis three times a week,* [redacted]*'s Choices for Care services have included nursing facility care, hospitalization for cardiac care and he is*

currently in an Adult Family Care placement in the community. While hospitalized, he developed Ascites, and requires a periodic paracentesis procedure. His needs must be carefully monitored as they can change rapidly. [redacted] also has multiple other complex medical conditions and his diet and nutritional needs are closely monitored by his home provider. [redacted] also loves living in the country, going for rides in the woods and fishing.

[redacted] is closely followed by his primary care physician. He is living in an Adult Family Care setting with an independent home provider and hosted through a local agency with specialized expertise in creating and monitoring individualized living arrangements. The host agency provides case management support, the independent home provider offers 24/7 care services. All involved agencies, the home provider and support services were chosen and approved by [redacted] and his legal guardian.

Outcomes

Prior to the implementation of the CFC Demonstration, 241 persons were on the waiting list for 1915 (c) services. During start up in 2005, all persons were moved from the waiting list. Waiting list counts peaked at 100 persons in 2006 and fluctuated between no waiting list and 80 persons during the recession. Since March of 2011, Vermont has operated the program with no individuals on the waiting list.

The CFC program routinely collects and reviews consumer feedback on experience of care and satisfaction. Periodic consumer surveys show that our consumer's perception of HHA case manager performance equals or exceeds that of AAA case managers, results also yield high levels of satisfaction with questions specific to choice and control in the home and community services, including choice of case management agency. In all case management areas, persons in the Highest and High needs group reported significantly higher ratings than those in the Moderate needs group who receive a more limited benefit package. A summary of several questions related to choice, control and case management across all participants, (High, Highest and Moderate needs) is provided in Table 1 below. A link to full survey results is here: CFC 2015 Consumer Survey.

Table 1: Choices for Care, Consumer Experience of Care Survey Highlights All Groups

Consumer Survey Question	2015 Results
How would you rate the amount of choice and control you had when you planned the services or care you would receive? (% excellent or good)	85%
How would you rate how well people listen to your needs and preferences? (% excellent or good)	90%
I get the services I need the way I want to get them. (% agree or strongly agree)	90%
My current residence is the setting in which I choose to receive services. (% agree or strongly agree)	97%
My services help me to achieve my personal goals. (% agree or strongly agree)	90%
How satisfied are you with your case manager? (% very or somewhat satisfied)	93%
I feel I have a part in planning my care with my case manager. (% always or almost always)	85%
My case manager helps me understand the different service options that are available. (% always or almost always)	84%
My case manager coordinates my services to meet my needs. (% always or almost always)	86%

In addition to direct consumer feedback, the State has advanced a number of independent program evaluations from the University of Massachusetts Medical School that describe general program performance measures and quality outcomes. These can be viewed at the following link: UMASS Evaluations, Consumer Choice and Control.

Offering participants full choice based on clinical need has been successful in shifting the balance from skilled nursing facility to community care. In all but three regions the balance is 50/50 with several regions lowering skilled nursing facility care even further. As more participants who require skilled nursing services 24/7 opt to stay at home, the medical complexity of in home care has been increasing. At the same time Vermont has seen a gradual increase in consumers in home and community care options choosing HHAs as their care manager, from approximately 40% in 2010 to 52% in 2016. Vermont is second highest after California relative to the percent of persons who self or surrogate manage their care giver services; over 50% of all Personal Care Services in CFC are self or surrogate managed.

CFC data reports can be viewed at: DAIL CFC Data Reports.

Section II Standards and Options for Alignment

Federal and State Standards (1915 (c), Older Americans Act, State Designation Regulations)

The State of Vermont understands that consumer choice, coupled with beneficiary protections (e.g., options counseling and provider requirements to address potential conflict of interest) under the Choices for Care Program may not be adequate to address the requirement in 42 CFR 441.301 (c)(1)-(3) that states:

> *Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process*

Vermont law assigns a geographic area to each of the twelve HHAs. Given the unique nature of Vermont's delivery system, the small size of the State and the importance of consumer choice as a fundamental tenet of the CFC program, Vermont has also historically requested federal approval under the Older Americans Act State Plan to allow Area Agencies on Aging to provide both case management and direct services to assure access to necessary services.

In addition, Vermont has just begun a provider and stakeholder planning process to promote a model of care based on full integration of service delivery such as those employed in Patient Centered Medical Homes, Specialized Health Homes and Accountable Care Organizations.

We are requesting your determination as to whether the current program operations meet CMS criteria for the "geographic exception" process contemplated in the HCBS regulation while the State plans for its next steps in delivery system transformation and quality improvement.

Proposed Action Plan

Vermont has been engaged in a multi-pronged effort to promote the full integration of primary care, mental health and MLTSS delivery networks in support of a comprehensive and seamless person centered model of care. Vermont has had success with integrated care approaches that connect providers across the care continuum of services and will be discussing MLTSS integration options relative to:

- Enhancing current Patient Centered Medical Homes and Services and Supports at Home (Blueprint for Health and SASH);
- Creation of a Specialized Health Homes; and/or
- Alignment of MLTSS with a Medicaid Accountable Care Organization (ACO) for consistency across public and private payers.

On June 7, 2016 a stakeholder planning group comprised of advocates, consumers, providers, primary care and other stakeholders came together to advance planning for a fully integrated model of care. HCBS standards will be an important element of all planning. Based on our immediate next steps and 2016 planning already underway, Vermont intends to continue stakeholder engagement in intensive planning process. Any change in the delivery system for Choices for Care that the State might contemplate will require further discussion with our advisory boards, stakeholder engagement and public comment prior to the State making a commitment on final direction.

Options that contemplate new State staff, new entities or that change the statutory role of HHAs in Vermont will require approval through the State's legislative process during the January – May of 2017 Legislative session. In addition, any action during the 2017 session may trigger changes in rules and regulations that could take another three to twelve months to fully implement. Thus, operational changes would not be expected earlier than October 1, 2017 and more feasibly July 1, 2018. This timeline will also need to coordinate any changes in AAA designation and services with the submission of our next Older Americans Act State Plan in September of 2018.

The State's proposed planning activities are summarized below and outlined in more detail with expected timelines in Section III.

1. Request a determination from CMS for an HCBS exception or other policy solution based on: the State's current Section 1115 demonstration model; a determination that the HHAs and AAAs, who provide both direct care and case management services, are the only qualified entities for the persons they serve.
    a. Vermont could provide CMS additional detail regarding the HHA and AAA structure and regional designations if this would be helpful.

b. Vermont could also encourage current providers to separate lines of business for case management services by creating different corporate entities if CMS determines this to be a required step for the current CFC system.

2. **Enhance Choices for Care program standards**, including clarification and monitoring of acceptable conflict of interest protections and separation of functions within provider agencies for staff supervision and decision-making for the provision of direct services and case management. This work will be accomplished as part of our comprehensive quality improvement plan and HCBS alignment work already in process with completion expected December 2016.

3. **Engage Broad Based Planning**, using the timeline and action steps in Section III engage stakeholders in a meaningful assessment of delivery system needs and options for improvement, including how to best align services and supports in light of HCBS rules, medical complexity of Choices for Care participants and desired health care reform goals across public and private payers.

4. **Options for HCBS alignment to be considered during 2016 planning** (see Section III steps) include but are not limited to:

   a. **Maintain Choice and Support Primary Care Integration**: Adoption of interdisciplinary/agency teams similar to Specialized Health Homes to integrate LTSS/CFC and physical health care. Initial considerations are outlined below.

      - Aligns with Health Home, ACO and/or Patient Centered Medical Home models
      - May not meet CMS HCBS standards
      - May require additional Section 1115 demonstration waiver for HCBS standards to achieve desired integration with primacy care and/or Medicaid ACO models
      - May require adjustments to the State's Older Americans Act State Plan in 2018
      - Would allow for beneficiary choice
      - May still require CMS determination that integrated care team meets the "geographical exception" standard as contemplated in HCBS rule

   b. **Create New Entity**: Create a new type of care management entity. This could include a separate case management provider for regional or statewide service provision. Would require new legislative appropriation and potential changes to CFC regulations and program rules. Initial considerations are outlined below.

      - Could add additional administrative infrastructure and divert resources away from direct care
      - Would meet CMS HCBS standards
      - May not align with Health Home model and standards
      - Will not offer beneficiary choice
      - Could fragment services if provider is not fully integrated into existing care teams

c. **Increase State Staff and Enhance Role:** Adopt a State run model for care management. This would involve an increase in State staff positions to deliver case management services. Initial considerations are outlined below.

   - Would require legislative approval
   - Provides safeguards for consumer and ensures non-duplication of services
   - May result in additional infrastructure and could divert resources away from direct care
   - Would meet CMS HCBS standards
   - Will not offer beneficiary choice in case management provider
   - May not be feasible or approved by legislature given current budget shortfalls
   - Potentially inconsistent with the direction of current health reform care and provider led integration efforts

d. **Designate a Single Provider Per Region:** Designate a single provider per region and request CMS exception as contemplated in Federal HCBS rules. Initial considerations are outlined below.

   - AAAs and HHAs each offer different expertise that is important to CFC participants.
   - May result in destabilization of providers not designated as single entity
   - Would eliminate consumer choice

Vermont seeks CMS collaboration on how to best achieve alignment between differing federal and state standards as Vermont plans for greater integration with Patient Centered Medical Homes, Specialized Health Homes and Accountable Care Organizations for the Choices for Care program. Vermont shares the goal of ensuring participant access to effective, high quality case management and feels that beneficiary choice should remain the overarching tenant of the Choices for Care Section 1115 Demonstration program. Vermont seeks CMS assistance in developing a policy strategy that aligns these objectives. Our proposed planning process and timeline to address these and other integration issues is outlined in Section III.

Section III Action Plan and Timeline

Outlined below and on the following pages is Vermont's 2016 -2017 action plan for: assessing options and innovations in integrating care for Medicaid enrollees across physical health, mental health and long term services and supports; and reviewing those options for alignment with State and federal rules and emerging innovations under the Global Commitment to Health Section 1115 Demonstration.

Vermont Medicaid Pathway/HCBS Action Steps 2016	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1. Establish membership and work group meeting schedule, host June kick-off session.								
2. Collaborate with CMS to identify policy and operational alignments relative to HCBS and Specialized Health Home and ACO models.								
3. Identify delivery system transformation goals: solicit state staff, provider, stakeholder, and consumer/advocate concerns with current delivery model, program requirements (including alignment with planned updates to HCBS standards) and payment methodologies.								
4. Preliminary review of draft scope to determine if program or legal requirements present any known limitations or impediments to reform initiatives.								
5. Review final draft scope and discuss delivery system design models to support VT integrated model of care, including alignment with HCBS, health home, OAA and other federal.								
6. Review results of HCBS provider self-assessments and address implications in planning.								
7. Identify delivery system design elements that specifically support an integrated delivery system, including alignment with VT Blueprint for Health and planned HCBS rule updates and discussion of how to address delivery system changes to eliminate conflict of interest issues and support meaningful beneficiary choice in person-centered planning.								
8. Review other states' models and opportunities to enhance funding (e.g., Medical Home and/or ACO investments in community based care) as applicable. Models may include, but not be limited to: specialized health home models; new case management entities for person- centered planning; increased State staff for case management and person-centered planning; designation of one provider per region to provide case management services; other innovative models that may support the State's goals of								

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Vermont Medicaid Pathway/HCBS Action Steps 2016	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
maintaining enrollee choice and comprehensive interdisciplinary teams.								
9. Identify alternatives to current payment models that support the VT integrated model of care and the proposed delivery system design model.								
10. Identify Quality and Oversight Framework including any new performance and outcome measures and alignment with planned HCBS updates.								
11. Present preferred design options for delivery system and payment reform, ensuring one drives the other. Solicit input from providers, stakeholders and consumer/advocates. To include outreach to providers not on planning team and formal and informal stakeholder feedback sessions.								
12. Identify standards that may require updating to strengthen beneficiary protections and mitigate conflict of interest								
13. Determine Resources and/or Technical Assistance needed to implement preferred delivery system and payment reform models for both short and long-term sustainability (e.g. data, staffing, change in standards or certification processes).								
14. Identify which features of the proposed reforms, if any, would require approval from CMS.								
15. Define approach (e.g., SPA, GC Demonstration amendment, GC technical review or appendix change) and timeline for any necessary CMS review.								
16. Identify any Statute, regulatory, policy or budgetary changes needed.								
17. Determine provider readiness for reforms and identify any final obstacles.								
18. Develop a proposed 2017 implementation date and multi-year plan for operational changes to support reform model, align with HCBS and other State and Federal standards & solicit feedback.								
19. Coordinate a timeline for any necessary changes between the OAA State Plan and CFC Demonstration.								
20. Seek approval from CMS and/or Legislature as needed								
21. Finalize implementation dates of operational changes.								

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Consumer Validation Survey Work Status - Meeting 11/20/17

AFC & TBI:

Kathleen Hamilton will survey participants April – June 2018. A couple of trail surveys will be completed in the southern part of the state (Bennington area) in December.

- Adult Family Care: 90 participants = 14 sample size
- TBI program: 85 participants = 13 sample size

Adult Day:

200 participants high/highest = 30 sample size

Follow up with Stuart re: Adult Day review schedule to determine if validation surveys can be done by Stuart on site visits. Or split between Kathy and Stuart.

Pending Provider Surveys

- 11 CFC
- 3 TBI

Andre will send list of providers to Angela and split the list. They will contact each provider and get the correct contact for the survey and send out the survey link by the end of November. Providers will have 2 weeks to submit.

Case Management Provider Surveys:

All case management provider surveys are on paper and need to be entered into the survey platform. Maybe Kathy can help with this task as she has done this for DS providers?

No need to do consumer validations surveys. Will incorporate the provider survey results into the case management certification site reviews and training.

Kennedy, Alice

From: Courcelle, Andre
Sent: Monday, September 25, 2017 3:41 PM
To: Tierney-Ward, Megan
Subject: DAIL Annual Report
Attachments: DRAFT TBI_Program_Page.docx

Hi Megan,
I have attached the draft for the TBI section for the report. I'm not sure how to pull a graph from the scorecard.
Thanks

Andre' R Courcelle
Quality & Provider Relations Program Director
Adult Services Division
Department of Disabilities, Aging and Independent Living
280 State Drive HC-2 South
Waterbury, VT 05671-2070
Office: 802 786-2516
Fax: 802 786-5055
andre.courcelle@vermont.gov

Adult Services Division – Traumatic Brain Injury Program

Program Overview

The Traumatic Brain Injury Program (TBI) is a specialized health population covered under Vermont's Global Commitment to Health1115 Waiver. TBI program offers rehabilitation focused services and supports to Vermonters age 16 and older who have experienced a recent moderate to severe traumatic brain injury. TBI is highly structured, community based program that assists individuals' to build skills and strategies for independent living in the community amongst family and friends.

If a person is found clinically and financially eligible they may choose which TBI provider they want to work with to identify personal goals and where they want to receive their services. TBI program offers an array of services including;

- Case Management/Service Coordination
- Life Skills Aid 1:1 support
- Residential
- Respite
- Crisis
- Environmental/Assistive Technology
- Counseling

Staff and Partners

The Quality Management Unit manages the TBI Program and includes 1.25 staff to manage applications and clinical eligibility around the state.

Partners who provide direct services are TBI Authorized Agencies.

Recent Developments and Accomplishments

A large focus this year has been on the new federal regulations for Home and Community Based Services (HCBS) settings characteristics and person-centered planning. A systemic evaluation and work plan was developed for TBI through a public process which is being used to strengthen policies and procedures for the program and to strengthen certification standards for Authorized TBI Agencies.

Future Directions

- Work will continue the HCBS regulations as it relates to home-based stings requirements and person-centered planning.

Adult Services Division – Traumatic Brain Injury Program

- A Statewide TBI Needs Assessment will be completed the results will be used to plan and create a new TBI State Plan.
- Will be a part of the National Core Indicators for Aging & Disabilities survey being implemented by the Division.
- Work will continue on redistribution of existing resources within Adult Services Division to better support the program and the people it serves.

Results

The TBI program served 96 people in SFY16

The TBI Program has three measures on the DAIL Score Card

- The percentage of people employed while in the Rehab program; 25% of the people were employed while in the Rehab Program
- Number of people that graduated to independent living from the Rehab program; Five people graduated from the TBI Program
- Number of people transitioned to CFC long-term services or TBI long-term services; Two people transitioned to CFC long-term services

Insert DAIL Score Card graphs

VERMONT

Overview

The Centers for Medicare and Medicaid Services (CMS) is responsible for making rules about Medicaid services. In 2014, CMS made new rules that help people who get Medicaid services. The new CMS rules protect your choice about where services are received. The new CMS rules also make sure that services:

- Are integrated in and give full access to the community, which is known as "Community Integration";
- Provide rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Support individual decisions;
- Let you choose what services you need; and
- Who provides the services to you.

The new CMS rules also require that you must have a written agreement if you live in a provider-run residential setting. This agreement must protect your rights in the same way it does for other renters and program participants. Before your rights can be modified, a needs assessment must be completed. You must be asked to agree to the needs assessment. The changes must also be justified in your individualized plan or support agreement.

You have been randomly selected to give us your opinion about the place where you currently live. Your participation for this survey is voluntary. Your opinions are very important. We hope you will choose to answer the survey. Your answers will help us understand how well your provider meets the new CMS rules.

Questions are organized into the following sections:

1. Information about you and where you receive services;
2. Physical characteristics about where you live;
3. Integration with the community;
4. Privacy, dignity and respect;
5. Individual control, decision-making and independence;
6. Your rights with respect to where you live.

Instructions for Interviewer Observation

Most of the questions are to be asked of the member and/or member's representative. A small portion are to be answered by the assessor based on his/her observation of the setting. These questions are flagged as, "To be completed by Interviewer".

Instructions for Conducting Interviews

The survey is designed to return yes/no answers to each question. If the individual responding to questions struggles to understand the question, examples or prompts to help clarify the question are included for many of the questions. To ensure that all consumers are answering the same question, please try to use first question as listed in the interview before moving on to additional prompts or examples. If the individual does not appear to understand the question after additional prompts or provides conflicting detail for the same question mark the response as "D/K".

This survey is designed for multiple types of residential settings, you will need to customize the terminology based on the person and type of setting you are visiting. For example in some cases, "housemate" may be more appropriate than "roommate"; "home" may be more appropriate than "room". In some cases, the provider may be a residential care or group home name "The Pines" and in other cases a family care home "The Smith's"; please use whatever name is most familiar to the person being interviewed. As you refer the "the provider" throughout the questions, please note that:

- Each question allows you to add a comments or observations. You are not required to add comments; however, if you feel that there are items needed for follow-up or requiring clarification that is important to the results, please use the comment box to add that information.
- The first section of the survey requires you fill out demographic information about the consumer, provider and location. DAIL will provide this information to you for each person and/or the provider staff assigned to work with you. Please make sure that you have the necessary details to fill-out the demographic information in order to complete the survey.

Questions

Questions regarding the assessment should be directed to:

Agency of Human Services:
Shawn Skaflestad, Quality Improvement Manager
(802) 241-0961
Shawn.skaflestad@vermont.gov

Developmental Disabilities Services Division:
Chris O'Neill, DAIL - DDSD Quality Management Team Leader
(802) 241-0332
Chris.ONeill@vermont.govAndre Courcelle,

Adult Services Division: Quality & Provider Relations Director (802) 786-2516
Andre.Courcelle@vermont.gov

Section 1 - DEMOGRAPHIC INFORMATION (To be completed with information provided by DAIL and/or Provider)

Member *This question is required.

Last Name: _____

First Name: _____

Who is completing the survey? (Add choices from drop-down here)

_____

Last Name of Person Assisting: _____

First Name of Person Assisting: _____

Relationship: (Add choices from drop-down here)

Date of Enrollment with Provider: _____

Provider Name and Mailing Address *This question is required.

Provider or Host Agency Name: _____

Provider Name: _____

Street or PO Box: _____

City: _____

State: _____

Zip Code: _____

Program and Setting *This question is required.

Program:

- ○ Choices for Care
- ○ Developmental Disability Services
- ○ Traumatic Brain Injury

Choices for Care Program Setting:

- ○ Adult Day
- ○ Adult Family Care
- ○ Enhanced Residential Care

Traumatic Brain Injury Program Setting:

- ○ Residential Care Home
- ○ Shared Living
- ○ Staffed Living
- ○ Supervised Living

Provider Service Location *This question is required.

Location Name:

Street or PO Box:

City:

State:

Zip Code:

Interviewer Completing Self-Assessment *This question is required .

Last Name:

First Name:

Office Telephone:

Email:

2 - PHYSICAL LOCATION CHARACTERISTICS

This section is to be completed entirely through interviewer observation.

2.1

Is the residence/service setting located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment (NF, IMD, ICF/ID or hospital)? *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.2

Is the residence/service setting located in a building on the grounds of, or immediately adjacent to, a public institution (e.g. prison or State-operated hospital)? *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.3

Is the residence/service setting one of multiple locations that the provider owns or operates on the same street? (Answer "no" if the residence/service setting is a duplex or multiplex and there are no others owned or operated by the provider on the street.) *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.4

Is the residence/service setting located in a gated/secured community for persons with disabilities? *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.5

Is the residence/service setting located in a farmstead or disability-specific community? *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.6

Is the residence/service setting designed specifically for persons with disabilities? (Please note for community-based home settings developed specifically and uniquely for one or two residents based on their needs and preferences, please check "No") *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.7

Are the individuals who reside/receive services in the setting primarily people with disabilities? (Please note for community-based home settings developed specifically and uniquely for one or two residents based on their needs and preferences, please check "No") *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.8

Is the service setting located in the same building as an educational program or school? *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ● No

Comment:

2.9

Is the setting located among other residential buildings, private businesses, retail businesses, restaurants, doctors' offices etc., so as to facilitate integration with the greater community? (For rural communities if the setting is commensurate with other locations seen in community or neighborhood, please respond "yes") *(To be completed by Interviewer.)* *This question is required.

- ○ Yes
- ○ No

Comment:

2.10

Notwithstanding DAIL approved security measures, is the setting free from gates, Velcro strips, locked doors and other barriers preventing residents from entering or exiting certain areas of the setting? *(To be completed by Interviewer.)* ***This question is required.**

- ○ Yes
- ○ No

Comment:

2.11

Are supports, such as grab bars, wheelchair ramps, bathroom seats and viable emergency exits, provided for individuals who need supports to move about the setting as they choose? *(To be completed by Interviewer.)*

***This question is required.**

- ○ Yes
- ○ No

Comment:

2.12

Are tables and chairs at a convenient height and location so that individuals can access and use them comfortably? *(To be completed by Interviewer.)* ***This question is required.**

- ○ Yes
- ○ No

Comment:

2.13

Does the physical environment support a variety of individual goals and needs (e.g., does the setting provide indoor and outdoor gathering spaces; does the setting provide for larger group activities as well as solitary activities; does the setting provide for stimulating as well as calming activities)? *(To be completed by Interviewer.)* ***This question is required.**

- ○ Yes
- ○ No

Comment:

2.14

Does the dining area afford dignity to diners, including by not requiring individuals to wear bibs and by not using disposable cutlery, plates and cups? *(To be completed by Interviewer.)* ***This question is required.**

- ○ Yes
- ○ No

Comment:

2.15

Does the setting post in a prominent location or otherwise furnish information on the provider's policies concerning individual rights? *(To be completed by Interviewer.)* ***This question is required.**

- ○ Yes
- ○ No

Comment:

Section 3 - INTEGRATION WITH THE COMMUNITY

Instructions to be Read to Member

I am here on behalf of the State because we're interested in learning about your experience at -PROVIDER NAME-. We especially want to make certain that you are treated with respect and have the same rights and freedom as other people who live elsewhere in this community.

I am going to ask questions that you can answer yes or no. You can explain your answer if you want to share more information. It should take about 30 minutes. *(Note to assessor: Members also can answer "Don't Know" but should not be prompted with this option.)*

What you tell me will be kept confidential and will not be shared with -PROVIDER NAME-. We will combine your answers with the answers of other people here at -PROVIDER NAME- and around Vermont.

Nothing you tell me will affect your eligibility for services. The information will only be used to improve services for people like you around the State.

Do you have any questions before we begin? If not, is it OK to start?

First, I have some questions about whether you have opportunities to do things in the community and here at -PROVIDER NAME-.

3.1

If you want to, can you go out into the community during the day? *(Interview prompt: For example, are you able to visit friends, go shopping or to a movie?)* *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.2

Does -PROVIDER NAME- tell you about things to do, like shopping, attending church, eating out or going to concerts, parades, movies or fairs? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.3

In the past month, have you gone shopping, to church or out to eat with family and friends? *(This does not include going to a job.)* *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.4

Have you been given information about available transportation? *(Interviewer prompt: For example, has anyone shown you how to use the bus or call a taxi)* *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.5

(If member uses a wheelchair, ask. Otherwise enter N/A): Have you been given information about wheelchair accessible transportation? *This question is required.

- ○ Yes
- ○ No
- ○ D/K
- ○ N/A

Comment:

3.6

If you want to, can you have a paid job? *(Interviewer prompt: For example, is there someone to help you look for or get ready for job, if you want one?)* *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.7

Have you told -PROVIDER NAME- that you wanted a job? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.8

Do you have a paid job? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.9

If you want to, can you volunteer in the community? *(Interviewer Prompt: For example, is there someone to help you look for volunteer work, if you asked?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.10

Have you told -PROVIDER NAME- that you wanted to volunteer somewhere? ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.11

Are you volunteering somewhere? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.12

Can you go anywhere you want inside and outside this house? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.13

Can people come and visit you anytime? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.14

Are you allowed to have guests stay overnight? *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.15

Do you have access to your money? *(Interviewer prompt: For example, can you buy things you need and make choices about how to spend your money?)* *This question is required.

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.16

Were you offered help setting up a savings or checking account that you control? *(Interviewer prompt: For example, has anyone ever helped you open a bank account?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.17

Do you have a savings or checking account that you control? *(Interviewer prompt: For example, does anyone else have to sign your bank slips?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.18

Do you have a choice in what services and supports you receive? *(Interviewer Prompt: For example, if you wanted more time out of the house or wanted to talk to a counselor, can you ask for that support?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

3.19

Do you have a choice in who provides your services and supports? *(Interviewer Prompt: For example, if you wanted different helper or wanted another place to live, do people listen to you?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

Section 4 - PRIVACY, DIGNITY & RESPECT

Next, I have some questions about how you're treated here at -PROVIDER NAME- and whether your privacy is respected.

4.1

Can you be alone if you want to be during the day? *(Interviewer prompt: For example, can you have a conversation with a friend in private? Do you have time without staff listening or watching?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

4.2

Do the staff members who support you while you are working or participating in an activity treat you the way you want to be treated? *(Interviewer prompt: For example, do helpers and staff listen to you?)* ***This question is required.**

- ○ Yes
- ○ No
- ● D/K

Comment:

4.3

Do you need help getting dressed? ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

4.4

Do you pick out your own clothes? ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

4.5

Does -PROVIDER NAME- give you a safe place to store your personal belongings? *(Interviewer Prompt: Do you have a safe place to keep your stuff at home?)* ***This question is required.**

- ○ Yes
- ○ No
- ○ D/K

Comment:

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COMMITTEE ON AGRICULTURE
SUBCOMMITTEE ON COMMODITY EXCHANGES, ENERGY, AND CREDIT

SUBCOMMITTEE ON NUTRITION

COMMITTEE ON THE BUDGET

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
VICE CHAIR, SUBCOMMITTEE ON RAILROADS, PIPELINES, AND HAZARDOUS MATERIALS

SUBCOMMITTEE ON ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT

SUBCOMMITTEE ON HIGHWAYS AND TRANSIT

Congress of the United States
House of Representatives

November 27, 2017

Honorable Seema Verma
Administrator
U.S. Centers for Medicare and Medicaid Services
200 Independence Avenue, Southwest
Washington, DC 20201

Dear Administrator Verma,

We are writing today in support of immediate changes to CMS' March 2014 "Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community." We are encouraged to hear that CMS is currently in the process of revising this guidance, and we hope that you will be able to provide us with a positive update in the very near term. We write today both to express our desire to see this guidance document changed, and to share our views on the value and importance of disability-specific congregate, farmstead, and lifesharing communities in the Medicaid program. As written, the guidance discriminates against these communities, as well as against other rural-based settings which offer individuals with disabilities an important choice as they consider the setting that best meets their individualized needs.

As you are aware, in January 2014 CMS issued a final rule on Home and Community-Based Services (HCBS) waivers. The intent of the rule was broadly supported, enshrining into regulation the importance of patient choice and dignity. Following publication of the final rule, in a March 2014 guidance document CMS took the position that disability-specific congregate and farmstead communities are more likely than other community-based settings to "isolate" individuals from the broader community and are therefore subject to a "heightened scrutiny" standard before CMS considers them to meet the home and community-based services standards. While we support protections which ensure that individuals receiving HCBS have full access to the benefits of community living, we believe the guidance document, as written, reflects a fundamental misunderstanding of how many disability-specific congregate, farmstead, and lifesharing communities operate.

We are particularly concerned that the guidance may have the unintended impact of discouraging and ultimately phasing out congregate and lifesharing models which promote individual independence, community integration, and enhanced quality of life for all served by these communities. These models, many of which are located in congregate and farmstead settings, are an important choice for Medicaid beneficiaries as they search for the particular setting that

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best fits their own individualized needs. In subjecting these communities to a heightened scrutiny standard, CMS has introduced significant uncertainty to the future of these communities.

By painting all congregate and farmstead communities with a broad brush, CMS threatens to remove a critical choice from individuals looking for a setting that provides individuals with a community that supports inclusion, not seclusion. We applaud CMS' intent in the 2014 final rule to protect patient choice and dignity, but urge CMS to revise its subsequent guidance to clarify that congregate and farmstead communities based on the lifesharing model are not subject to the heightened scrutiny standard. We understand that these communities would welcome third party certification (such as through the Center for Quality and Leadership) as an alternative to the current broad-brush policy.

Thank you for your time and consideration,

Sincerely,

John J. Faso
Member of Congress

Jacky Rosen
Member of Congress

Raja Krishnamoorthi
Member of Congress

cc: Brian Neale, Director, Center for Medicaid and CHIP Services
Tim Hill, Deputy Director, Center for Medicaid and CHIP Services
Michael Nardone, Director, Disabled and Elderly Health Programs Group
Ralph Lollar, Director, Division of Long Term Services and Supports
Melissa Harris, Senior Policy Advisor, Disabled and Elderly Health Programs Group

Definitions for Choices for Care Standards, Case Management Standards and Adult Day Standards

Conflict of Interest: Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of HCBS services must maintain a conflict of interest policy that is in line with the standards set by the Centers for Medicare and Medicaid in regulation. At a minimum, the entity (case manager/service coordinator) developing the HCBS person-centered plan may not be any of the following:

- Related by blood or marriage to the individual or to the paid caregivers of the individual
- Financially responsible for the individual
- Empowered to make financial or health-related decision on behalf of the individual
- Holding financial interest in an entity that is paid to provide care for the individual
- Other limitations as set by CMS according to federal rules.

Home and Community-Based Services (HCBS): HCBS services are person-centered services provided to an individual in their own home or in the home of another person and assist that person to continue residing in that setting while avoiding the need to live in a licensed residential care or nursing facility setting. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning and settings requirements for HCBS services.

NOTE: In Vermont, the federal HCBS rules must at a minimum apply to the following:

- Choices for Care home-based case management services
- Choices for Care Adult Family Care
- Adult Day services
- Traumatic Brain Injury shared living
- Developmental Services shared living

HCBS Setting Requirements: HCBS setting requirement are intended to assure individual rights, freedoms and full access to the community when a person lives in a provider owned/controlled home. Currently, that includes CFC, TBI and DS shared living providers such as Adult Family Care. HCBS settings requirements are set in regulation by Centers for Medicare and Medicaid Services (CMS).

Person Centered Planning: Person-Centered Planning is a process for supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning for HCBS services covered under Vermont's Choices for Care program and other similar HCBS long-term services and supports programs.

Modifications: "Modifications" are any individual-specific exception to the person-centered planning and HCBS setting requirements. Modifications to the HCBS settings and person-centered planning requirements must be documented and include the following:

(a) Identify a specific and individualized assessed need for modification
(b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan
(c) Document less intrusive methods of meeting the need that have been tried but did not work
(d) Include a clear description of the condition that is directly proportionate to the specific assessed need
(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification
(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
(g) Include informed consent of the individual
(h) Include an assurance that interventions and supports will cause no harm to the individual

Quality Management: Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 186 provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.
http://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT186/ACT186%20As%20Enacted.pdf

References:
CMS guidance: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/faq-planned-construction.pdf

CMS HCBS rules: **https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider**

Adult Services Division

HCBS Provider Self-Assessment Process

1. April 3, 2017 an email communication will go out to the following provider groups with a link to the survey.
    a. Area Agencies on Aging: Choices for Care Case Management Services
    b. Home Health Agencies: Choices for Care Case Management Services
    c. Authorized Agencies: Choices for Care Adult Family Care
    d. TBI Providers: TBI Program Services
2. The Survey end date is April 28, 2017.
3. Shawn Skaflestad is the AHS lead for the SurveyGizmo tool which will generate the survey communications to providers.
4. Andre Courcelle will be the ASD contact for ASD provider questions and for the ASD survey results.
5. Depe

Kennedy, Alice

From: Courcelle, Andre
Sent: Monday, September 25, 2017 3:41 PM
To: Tierney-Ward, Megan
Subject: DAIL Annual Report
Attachments: DRAFT TBI_Program_Page.docx

Hi Megan,
I have attached the draft for the TBI section for the report. I'm not sure how to pull a graph from the scorecard.
Thanks

Andre 'R Courcelle

Quality & Provider Relations Program Director
Adult Services Division
Department of Disabilities, Aging and Independent Living
280 State Drive HC-2 South
Waterbury, VT 05671-2070
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VERMONT

Case Management Standards & Certification Procedures

Older Americans Act & Choices for Care Programs

Revised January 1, 2017

State of Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
Adult Services Division
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Available in alternative format by request.

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I. INTRODUCTION

The Adult Services Division (ASD) within the Department of Disabilities, Aging and Independent Living (DAIL) recognizes that quality case management is a critical part of our long-term services and supports system and is crucial to the fulfillment of DAIL's mission. The mission of DAIL is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.

In order to ensure the statewide quality of case management services offered under Older Americans Act (OAA) programs and Choices for Care (CFC), ASD has instituted Case Management Standards and Certification Procedures. The purpose of this document is to establish minimum case management performance standards and to provide guidance for case management agencies and individual case managers. These standards and certification procedures apply to case management services offered under OAA programs and CFC. The Choices for Care Program Manual and Regulations provide more detailed policies and procedures specific to CFC.

DAIL authority to establish service standards and to certify providers of case management services under OAA programs and CFC is established in Vermont state statute, the Center for Medicare and Medicaid Services (CMS) approved Global Commitment to Health 1115 Waiver, and the Older Americans Act.

II. DEFINITIONS

A. **Case Management:** Case management is a professional service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes.

B. **Conflict of Interest:** Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of case management services must maintain a conflict of interest policy that is in line with the standards set by the Centers for Medicare and Medicaid (CMS). See Appendix A for a link to the CMS regulations.

C. **Home and Community-Based Services (HCBS):** HCBS services are person-centered services provided to an individual in their own home or in the home of another person. HCBS services assist individuals to maintain as much independence, community participation, freedom of choice and control over their lives as possible, while preventing the need to live in a licensed facility. The Centers for Medicare and Medicaid Services (CMS) regulates Medicaid funded HCBS services with regards to person-centered planning and settings characteristics.

D. **Modifications:** "Modifications" are any individual-specific exception to the person-centered planning process as required by the federal home and community-based services (HCBS) regulations. Modifications must be documented and include specific elements identified in Section IV. M.

E. **Person Centered Planning:** Person-centered planning is a process for supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning for HCBS services covered under Vermont's Choices for Care program and other similar HCBS long-term services and supports programs. See Appendix A for a link to the CMS regulations.

F. **Quality Management:** Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 124 and

the Vermont Government Accountability Office provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.

G. **Self-Neglect:** Self-neglect is an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs. This definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision (National Adult Protective Services Association).

III. AGENCY CASE MANAGEMENT STANDARDS

All agency policies governing case management activities under OAA and CFC programs listed in the section must be reviewed and approved by ASD. Changes made to the approved policies must be reviewed and approved by ASD prior to implementation.

Case management agencies are expected to be knowledgeable of and in compliance with all relevant state and federal laws and requirements. Case management agencies shall also ensure the requisite case management agency policies are in place, the case management agency is responsible to ensure that all case managers providing services under OAA and CFC programs comply with the ASD Case Management Standards & Certification Procedures and related case management agency policies.

Case management agencies shall have the following written policies and protocols:

A. **After Hour Coverage**: The protocol shall at a minimum ensure that people are able to leave a message with the agency when it is closed.

B. **Consumer Complaint and Grievance Policy**: The policies and procedures shall outline how the case management agency will respond to consumer complaints and grievances. The policies shall address how consumers are informed about agency policies, including the complaint and grievance policy, and will explain how the process works.

C. **Information and Referral Policy**: The policy shall state that the case management agency will accept and respond to requests for information and/or assistance from individuals, caregivers and other third parties.

D. **Mandated Reporting of Abuse, Neglect, and Exploitation Policy**: The policy shall address how the case management agency will respond in cases of suspected abuse, neglect, and/or exploitation of vulnerable adults. The policy must be consistent with the requirements of Vermont statute 33 V.S.A. § 6903 and DAIL policies. ASD shall coordinate review and approval of this policy with Vermont Adult Protective Services, at the Department's Division of Licensing & Protection.

E. **Self-Neglect Policy**: The policy shall define how the agency will serve adults identified as self-neglect. This may include a referral to the AAA (for adults age 60 and older) or the local Designated Agency (DA) for adult mental health services (for adults under the age of 60). In the case of CFC referrals, the case management agency selected by the person shall be responsible for serving the person identified as self-neglecting.

F. **Maximum Caseload Policy**: The policy shall state the maximum caseload size for case managers, the prioritization process for people accessing case management services, and the management of waiting lists for people who cannot be served at any given time.

G. **Case Management Supervision Policy**: The policy shall address how supervision is provided including accessibility of supervisors, review of client records, on-going feedback between the supervisor and case manager and timely performance evaluations of case managers.

H. **Orientation Training Policy**: The policy shall outline the orientation training for new case management staff.

I. **Training Policy**: The policy shall outline ongoing case management training designed to ensure that case managers will have the necessary range of knowledge, skills and abilities to provide high quality case management services.

J. **Quality Management Policy**: The policy shall outline the case management agency's ongoing Quality Management plan regarding case management services. (Refer to Section II. Definitions for a definition of Quality Management).

K. **Conflict of Interest Policy**: At a minimum, the policy shall: (Refer to Section II. Definitions for a definition of Conflict of Interest).
   1. Define conflict of interest,
   2. Describe the agency's process for preventing conflict of interest,
   3. Describe how case managers report potential conflicts of interest immediately with their supervisor,
   4. Describe the agency's process for correcting conflict of interest when it occurs.
   5. Describe that the case manager developing the person-centered plan shall not be any of the following:
      a. Related by blood or marriage to the individual or to the paid caregivers of the individual
      b. Financially responsible for the individual
      c. Empowered to make financial or health-related decision on behalf of the individual
      d. Holding financial interest in an entity that is paid to provide care for the individual
      e. Other limitations as set by CMS and in line with federal rules.

L. **Client Record Policy**: The policy shall include:
   1. The procedure governing their use, storage and removal.
   2. The conditions for release of information contained in the record.
   3. The requirements of authorization in writing by the person or legal representative for release of information.
   4. The maintenance of all records relating to the delivery and documentation of case management services for a minimum of 3 years and the maintenance of all financial records for a period of 7 years.
   5. Compliance with the Health Insurance Portability and Accountability Act.

M. **Background Check Policy**: The policy shall outline the background checks required in order for a person to be employed as a case manager. The policy must be

consistent with the DAIL Background Check Policy.

N. **Emergency Management Plan**: The agency shall have a plan describing how it will identify the critical functions and services it performs that must continue in the event of an emergency and include a plan as to how those functions and services will be provided during that time. The plan shall describe how the agency will collaborate and cooperate with local emergency planners and other local providers. The plan shall also describe how the agency will:

1. Identify persons who might require specific assistance during an emergency; and

2. Provide information and encourage people to develop a personal emergency preparedness plan. Provide assistance in developing the plan as necessary for needed assistance and support in the event of a natural or other emergency which may result in disruption of service

   and/or personal harm. Involvement and consideration of family caregivers, as well as other natural supports must be part of the process.

O. **Agency Confidentiality Policy**: The agency shall have a policy that is no less stringent than the Agency of Human Service Consumer Information and Privacy Rule.

P. **Smoking Policy**: Agency shall have a smoking policy that at a minimum prevents staff from smoking in the presence of people receiving services.

Q. **Limited English Proficiency Policy**: Agency shall have a policy that describes how people with limited English proficiency will be assured meaningful access to services provided by the agency. The policy must comply with federal regulations.

IV. INDIVIDUAL CASE MANAGER STANDARDS

A. The case manager must be knowledgeable of and comply with all agency policies and standards.

B. A case manager shall be knowledgeable about the full range of services available to individuals in their region and shall ensure that individuals are informed of available resources and services. The case manager will make any needed referrals.

C. A case manager shall provide service in an efficient, effective and collaborative manner to avoid duplication of services, unnecessary costs, and administrative tasks.

D. A case manager shall respond to requests for information and/or assistance from individuals in a timely manner.

E. A case manager shall inform all individuals of the agency's grievance procedures.

F. To the extent possible, a case manager shall ensure the person receives person-centered services in the least restrictive and most appropriate setting in accordance with his or her needs and preferences, as required by the U.S. Supreme Court Olmstead decision. (See Appendix A.)

G. A case manager shall recognize self-neglect behaviors and offer intervention, when such behaviors jeopardize the person's wellbeing. For people not enrolled in Choices for Care, a referral shall be made to the AAA (for adults age 60 and older) or the regional Designated Agency for adult mental health (for adults under age 60).

H. A case manager shall respect the person's rights, strengths, values and preferences, encouraging the individual to create, direct and participate in their individualized written person-centered plan to the fullest extent possible.

1. The person may involve a caregiver or a legal representative in decision making. A legal representative may be a legal guardian appointed by probate or family court with specific duties outlined in the court order, an attorney or power of attorney.

2. People have the right to make their own decisions and decide who they want to be involved in decision making. In the event that a person has a guardian or agent, the case manager will involve him/her in accordance with that individual's legal responsibility. When a person does not appear to have the capacity to make decisions and there is no legal guardian or agent the case manager shall refer to the agency policy on self-neglect.

3. The case manager will provide a person-centered process that is timely and occurs at times/locations of convenience to the individual.

4. Person-centered planning must reflect a process that the setting in which the individual resides is chosen by the individual.

5. A case manager shall ensure that a person has the right to receive services under conditions of acceptable risk. "Acceptable risk" is the level of risk an individual and/or his/her guardian, if there is one, is willing to accept after the informed consent process. A case manager may work with the individual and the service provider to develop a Negotiated Risk Agreement when necessary.

I. Assessment: A case manager, with input and participation by the person and his/her support network, shall assess the individual's strengths and needs using the assessment tool(s) approved by ASD.

1. A case manager shall update the assessment at least annually, or at any time there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed.

2. A case manager shall make every effort to assure the completeness and accuracy of the initial assessment and any subsequent reassessments.

3. Assessments need to be completed in compliance with Choices for Care and other program protocol.

J. Goals: When a person requires case management assistance for complex issues the case manager along with the individual and his or her support network shall identify person-centered goals.

K. Planning: Using the information from assessments and in consideration of the individual's person-centered goals, the case manager shall discuss all available options with the individual and his or her support network; and, agree upon strategies built upon the strengths of the individual to achieve these goals. Strategies shall describe the specific service or support to be provided, the person responsible for carrying out the strategies and the target date as agreed upon by the person. The initial goal and strategy identification shall be completed within 60 days of completion of the assessment.

L. Monitoring and reviewing: A case manager shall monitor the delivery of formal and informal services and supports to ensure that services are being provided as planned, to ensure that the person's identified needs are being met, and goals are being pursued. Monitoring shall include regular contact with the individual, caregivers, and service providers. The individuals' goals and strategies shall be updated to reflect the annual reassessment or more frequently if there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed. For more specific guidelines, refer to program and agency requirements.

M. Documentation: A case manager shall maintain current, complete and accurate paper or electronic files for each person including but not limited to:

1. A written release of information or documentation of why a written release of information could not be obtained.

2. The appropriate assessment form designated by DAIL.

3. Person-centered plan which is driven by the individual. The plan must:
   a. Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports the individual's strengths and preferences.
   b. Reflect the setting in which the individual resides is chosen by the individual.
   c. Reflect clinical and support needs as identified through an assessment of functional needs.
   d. Reflect individually identified goals and desired outcomes.
   e. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of paid services.
   f. Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
   g. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
   h. Identify the individual and/or entity responsible for monitoring the plan.
   i. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
   j. Be distributed to the individual and other people involved in the plan.
   k. Include those services, the purchase or control of which the individual elects to self-direct.
   l. Prevent the provision of unnecessary or inappropriate services and supports.

4. Modifications, or exceptions, to the CMS required HCBS person-centered planning process must be documented and include the following: (see definition of Modifications)
   a. Identify a specific and individualized assessed need for modification

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan
c. Document less intrusive methods of meeting the need that have been tried but did not work
d. Include a clear description of the condition that is directly proportionate to the specific assessed need
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
g. Include informed consent of the individual or their legal representative
h. Include an assurance that interventions and supports will cause no harm to the individual.

5. Case notes that shall focus on the individual's progress and any emergent issues that need to be addressed.

6. Other correspondence received or sent which is relevant to individual.

7. Other documents required by specific programs and services, such as copies of applications, notice of decisions, etc.

8. Guardianship/ Power of Attorney and other advanced directives must be documented in the assessment.

9. If the case manager is taking direction from a legal representative, there must be a copy of the legal documentation maintained in the individual's case management record. (e.g. Guardianship or Power of Attorney documents.)

10. Documentation of Negotiated Risk Agreement (if applicable).

11. Documentation of required reporting of suspected abuse, neglect and exploitation.

V. CERTIFICATION PROCESS

A. A case management agency is deemed certified for one to three years by the ASD when the following components have been met:

1. An Area Agency on Aging have a current approved area plan on file with the ASD ora Home Health Agency has received designation to provide Medicare home health services in the State of Vermont by Division of Licensing and Protection (DLP) through the designation or survey process.

2. ASD has completed a certification review.

3. The agency has demonstrated compliance with all requirements found in the Case Management Standards or has shown progress that is acceptable to ASD towards resolving unmet case management standards at time of initial certification or re-certification.

B. The ASD certification process includes:

1. Verification that an Area Agency on Aging has a current approved area plan on file with ASD or verification that a Home Health Agencies has received designation to provide Medicare home health services in the State of Vermont, by Division of Licensing and Protection (DLP) through the designation or survey process.

2. Approval of the policies required in the Case Management Standards.

   a. Policies shall be submitted to ASD in a manner which allows ASD to maintain an electronic file for each agency.

   b. Policies which have been approved as part of the AAA Area Plan process or as part of the Home Health Agency designation do not have to be resubmitted at the time of the initial or recertification process. (See Appendix D for a list of those policies which are included in the Agency on Aging Area Plan or Home Health designation process.)

   c. Policies relating to case management services which have been updated or altered since the previous certification review must be submitted to ASD for approval prior to the certification review process.

3. Review of complaints received and documented at ASD during the past year.

4. Consultation with the following community partners regarding the quality of case management services provided by the agency, as needed:
   - Adult Day providers
   - Waiver Team Members
   - Public Guardians

- Field Directors

5. An on-site review at the case management agency.

   a. Each agency will be notified of the review within one (1) week of the pending on- site visit. ASD reserves the right to make unannounced agency site visits with the intention to conduct a targeted review.

   b. The on-site portion of the review will last for three (3) days but may be extended at the discretion of ASD. It will include:
      - A review of individual CFC and/or OAA case management files.
      - Home-based interviews with individuals who receive case management services through CFC or OAA programs. Interviews may also include family members, surrogates and/or caregivers.
      - Individual interviews with case management staff.
      - Interviews with the Agency Director, Long Term Care Director, and/or Case Management Supervisor(s) to discuss the quality of case management services, the implementation of policies and procedures, and program understanding within the agency.
      - An exit interview with the agency director and others the director may choose to invite. This interview will summarize the preliminary findings of the review.

   c. The review sample will be limited to 4 to 6 individuals participating in High/Highest Needs CFC and/or OAA programs. The sample selection will be announced during day one of the review and may be expanded at the discretion of ASD. Records of other recipients of services may be reviewed as required.

   d. The discovery period of the review process will last no more than fourteen (14) consecutive days. This timeframe may be extended by mutual agreement between ASD and the agency.

   e. A written report addressing the results of the Certification Review will be available to the agency within thirty (30) days from the end of the review process.
      - The written report will consist of a brief letter which states the date of the review under discussion and the Review Grid completed by the DAIL reviewer at the time of the review.
      - A brief statement of particular areas of strength of the agency.
      - A statement of whether all of the Standards were met or not. If any area was not met, the letter will refer the reader to the Review Grid.
      - Any corrective action plan required from the agency must be received by ASD within 15 days from the date the agency received the ASD written report of the results of the quality review.

6. The final review report will have one of the following recommendations.

    a. Three-year certification: No corrective actions or recommendations.

    b. Two-year certification: Granted at the discretion of ASD if the agency's corrective action will bring an unmet standard into full compliance within a month of submittal to ASD.

    c. One-year certification: Granted at the discretion of ASD if the agency's corrective action plan will bring an unmet standard into full compliance after follow-up review visit(s).

    d. Suspension of certification: Granted at the discretion of ASD pending corrective action plan acceptance and follow- up review.

7. Certified Case Management agencies will be listed on the DAIL website. A redacted copy of the certification documents will be available to the public upon request.

8. The following documents will be used as technical references during the Certification Review process:
    a. Case Management Standards & Certification Procedures for Older Americans Act Programs and Choices for Care

    b. Case Manager Training Process

    c. Choices for Care High / Highest Needs Program Manual

    d. Older Americans Act and Accompanying Regulations

VI. APPEALS

The decision to suspend certification or to decertify may be appealed to the Commissioner of the Department of Disabilities, Aging and Independent Living.

1. The agency shall file for an appeal within 10 working days of a notice of suspension or decertification.

2. The Commissioner shall hear the appeal within 45 days of notice from the agency.

3. The Commissioner shall issue her or his decision in writing within 30 days of the hearing.

4. The agency's certification shall remain in place during the appeal process.

5. These deadlines may be increased if agreed to by both DAIL and the case management agency.

APPENDIX A

State and Federal Statutory Authority

I. **State Statute**: The Department of Disabilities, Aging and Independent Living has statutory authority to manage programs and protect the interests of older Vermonters and Vermonters with disabilities within Title 3, Chapter 53, Subchapter 004, Section 3885a of Vermont State Statutes.

The Commissioner has the authority to determine the policies and to exercise the powers and perform the duties required for the effective administration of the Department within Title 3, Chapter 53, Subchapter 003, Section 3052 of Vermont State Statues.

II. **Choices for Care**: Choices for Care is managed under Vermont's Global Commitment to Health 1115 Waiver. The Centers for Medicare and Medicaid Services (CMS) sets parameters for operations and quality management in the Code of Federal Regulations (State Assurances), Vermont's Special Terms and Conditions and Comprehensive Quality Strategy.

III. **Home and Community-Based Services (HCBS) Medicaid Regulations** – New HCBS Federal regulations (2014) set forth new requirements for HCBS settings standards and person-centered planning for people receiving services in home-based settings. The regulations are intended to enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

IV. **Older Americans Act**: The Older Americans Act (OAA) requires the State to be responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all state activities under the Act. Vermont is also responsible for setting specific objectives for each area for all services under the Act. 42 U.S.C.§3025 (a)(1)(c).

Vermont uses Title III-E funds to support case management activities. Vermont is required to establish standards and mechanisms designed to assure the quality of services, and to establish quality standards and mechanisms and accountability. 42 U.S.C.§3030s-1(e)(l).

OAA regulations require Vermont to develop policies governing all aspects of programs operated under Title III and to be responsible for the enforcement for these policies. (45C.F.R.§§1321.11 and 1321.17).

V. **Olmstead Decision**: On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate;

(2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

VERMONT

CERTIFICATION STANDARDS FOR ADULT DAY SERVICES IN VERMONT

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

280 State Drive, HC2 South
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I. Definition & Goals of Adult Day Services

A. Definition: Adult day services are community-based non-residential services designed to assist adults with physical and/or cognitive impairments to remain as active in their communities as possible by maximizing their level of health and independence and ensuring their optimal functioning. Adult day centers provide a safe, supportive environment where participants can receive a range of professional health, social and therapeutic services. Adult day services also provide respite, support and education to family members, caregivers, and legal representatives.

B. Adult day centers shall meet the following goals:

1. Foster respect, dignity, and a sense of well-being for the individual being served.

2. Respect individual rights, strengths, values, privacy, and preferences, encouraging individuals to direct and participate in their own plan of care and services to the fullest extent.

3. Promote the individual's optimal level of independence in a community-based setting.

4. Maintain and, where possible, enhance the individual's present level of functioning as long as possible, preventing or delaying a more restricted life style.

5. Foster the development and maintenance of social skills and interaction.

6. Promote support, respite and education services for family members, caregivers, and legal representatives.

7. Serve as an integral part of the community service network.

II. Certification Process for Adult Day Centers

A. Initial Certification: In order for an adult day center to become certified to provide services through the Department of Disabilities, Aging and Independent Living ("the Department"), the center shall meet the Vermont Standards for Adult Day Services as outlined in this document. Certification by the Department also fulfills the Centers for Medicare and Medicaid Services (CMS) definition of "state certified" in regards to the eligibility criterion for Medicaid beneficiaries. The certification process is as follows:

1. New adult day centers shall inform the Department of their intent to seek

initial certification.

2. The new adult day center shall submit information to the Department to answer the following questions:
   a. Is there an unmet need for adult day services in the target area and can the demographics of the target area support the project?
   b. Do the stakeholders in the target area support the proposed program?
   c. Is local transportation sufficient to get potential attendees to the proposed program?
   d. What is the prosed budget including income projections?
   e. Will the program design and proposed space meet the Adult Day Standards?

3. Upon satisfactory demonstration of unmet need and that the opening of a new Adult Day program will not adversely affect any existing adult day program, the Department shall consult with the Vermont Association of Adult Day Services and schedule a visit for an initial certification.

4. The Department shall complete a site certification assessment form after the visit, citing standards as "met" or "unmet".

   a. The initial certification review report shall be based on information received no more than 10 business days from the date of the site visit. This timeframe may be extended by mutual agreement between the Department and the center.

   b. If all standards are met, the adult day center shall be certified.

   c. If any standards are unmet, the application for certification shall be denied. The program may bring the unmet standards into compliance and reapply for certification.

5. Initial certification of new centers shall not be for more than one year.

B. Maintaining Certification: An adult day center must continue to comply with the Vermont Standards for Adult Day Services for certification to remain in effect.

   1. The Department may perform a scheduled and announced site certification review at previously certified adult day centers no more than once a year, but reserves the right to perform an unannounced site visit at any time to verify that the center is operating in compliance with the Standards for Adult Day Services in Vermont.

   2. The annual review report shall be based on information received no more

than 10 business days from the date of the site visit. This timeframe may be extended by mutual agreement between the Department and the agency.

3. The Department shall complete a site certification assessment report after the visit, citing standards as "met" or "unmet" and submit that report to the center within 20 working days after the end of the review.

4. If any Standard is unmet, within 25 working days the adult day center shall develop and submit to the Department a plan of action, including mutually agreed upon timelines for completion, to comply with all of the Standards for Adult Day Services in Vermont. The Department shall respond to the plan of action within 10 working days.

5. If the plan of action is not accepted in full, the adult day center shall submit a revised plan within 15 working days. The Department shall respond to this revised plan within 10 working days.

6. If the revised plan of action is not accepted in full the Department may take one or more of the following actions:
   a. Suspend Certification. This includes suspension of the center's ability to bill Vermont Medicaid for services.

   b. Revoke Certification. This includes revocation of the center's status as a Vermont Medicaid provider.

7. The Department may certify centers for up to three years depending on the outcome of the certification review.
   a. Centers whose review leads to no corrective action requirements and no other significant deficiencies shall be certified for three years.
   b. Centers whose review identifies only minor deficiencies shall be certified for two years.
   c. Centers whose review leads to a requirement for a corrective action plan shall be certified for one year.

8. The decision to suspend or revoke certification may be appealed to the Commissioner. The center shall file for an appeal within 10 working days of a notice of suspension or revocation. The Commissioner shall hear the appeal within 45 days of notice from the center. The Commissioner shall issue her or his decision within 30 days of the hearing. The center's certification shall remain in
   place during the appeal process. These deadlines may be increased if agreed to by both the Department and the center.

9. In the event that a center closes as a result of suspension or revocation of its certification, the Department will work with the center whenever possible to transition participants to another care setting.

10. Current certificate of certification shall be publicly displayed at the adult day center.

11. An announcement stating that the annual site certification assessment is available to the public upon request shall be posted next to the current certificate of certification.

III. Governing Body

A. An adult day center shall have a governing body.

B. The governing body shall hold the full legal authority and responsibility for the operation of the adult day center.

C. A governing body membership list shall be kept on file at the center and shall include the names, addresses, and telephone numbers of the governing body members.

D. The governing body shall be responsible for developing philosophy and mission statements that reflect the needs of the participants and their family members/caregivers/legal representatives as well as the care and services the center is committed to providing.

E. The governing body shall meet at least quarterly. For centers which are part of larger organizations, the Adult Day program shall be on the agenda of the full organization's board at least quarterly. Agendas and minutes shall be on file at the adult day center to verify times, content, and attendance for each meeting.

IV. Quality Management

Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 124 and the Vermont Government Accountability Office provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.

A. A quality management process shall be in place to assess, monitor, and improve the quality of the program and the services provided on an ongoing basis, including compliance with these Standards, other relevant policies and regulations (for example Choices for Care and Day Health and Rehabilitation Services) and the Outcomes for Adult Day Programs established by the Department.

B. The quality management process shall include regular reviews of the care of individuals served by the center. This review shall assess the overall functioning of the participant, the continued appropriateness of the current care plan, and changes that need to be made to the care plan.

C. The quality management process shall include regular reviews of the programs offered by the center including the modification or deletion of existing programs or addition of new programs, implemented as a result of consumer direction or choice, or implementation of best practices.

D. The quality management process shall include a self-assessment of program alignment with the applicable federal HCBS rules.

E. The quality management process shall include at least an annual process whereby important stakeholders can provide formal feedback to the center. These stakeholders shall include participants, caregivers and community partners and anyone else the center deems appropriate. The format of this process is left to the discretion of the center so as to allow it to utilize the information obtained from the evaluation to improve programs and the operations of the center. Any results from the process shall be made available for public review.

F. Participants and family members shall be involved in the quality management process.

V. Staff

The following section applies to persons employed full-time or part-time by the adult day center. For each employee that holds more than one job responsibility, they must adhere to the higher standard of qualification.

A. There shall be a written, dated job description for each staff position that specifies at least:

1. Qualifications for the job.

2. Job responsibilities.

3. Line of supervision.

B. An adult day center shall employ staff that meet the following qualifications:

1. Administrator: Job responsibilities of an administrator shall include, but not be limited to fiscal management and development, coordination, supervision, and evaluation of services provided by the adult day center. The administrator shall also be responsible for establishing and

maintaining relations between the center and the larger community and assuring that the center complies with the Standards for Adult Day Services in Vermont. Depending on the organizational structure of the adult day center, the same individual may fulfill the administrator and program coordinator positions. In this case, the individual shall have the minimum qualifications for the administrator.

An administrator shall have the following minimum qualifications:

a. A Master's Degree with one (1) year supervisory experience and preferably with one (1) year fiscal management experience; OR

b. A Bachelor's Degree with 3 years' supervisory experience in a social or health service setting and preferably with one (1) year fiscal management experience; OR

c. Comparable technical and human service experience, fiscal management experience, and demonstrated competence as a manager, preferably in a health or human service setting.

2. Program Coordinator: Job responsibilities of a program coordinator shall include, but not be limited to organization, implementation, and coordination of the daily operation of the adult day center in accordance with participants' needs and any mandatory requirements under the direction of the administrator.

A program coordinator shall have the following minimum qualifications:

a. A Bachelor Degree in health or social services or a related field, with one (1) year supervisory experience in a social or health service setting; OR
b. Comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

3. Registered Nurse (RN): The job responsibility of the RN shall include completing health assessments for all participants, contributing to the development of a written plan of service for each participant/caregiver that is based on abilities and needs as identified in the assessment, evaluating and documenting the ongoing services provided for each participant, providing instruction and supervision to all direct care staff regarding each participant's health care needs and nutritional needs and delegating nursing tasks as appropriate, and practices according to the standards for registered nurses as identified in the Vermont Nurse Practices Act.

The RN shall have the following minimum qualifications:

a. Vermont Registered Nurse (RN) license

b. A minimum of l year applicable experience. It is preferable that the experience is with elders and/or persons with chronic impairments.

4. Social Worker: Job responsibilities of the care manager/social worker shall include participant/caregiver support, contributing to assessments and plans of service, assisting participants/caregivers to access and utilize community resources, discharge planning, and documentation of services provided.

   The care manager/social worker shall have the following minimum qualifications:
   a. An MSW and at least one year of professional work experience OR
   b. A BSW and 2 years of experience OR
   c. A current Vermont Registered Nurse (RN) license and 1 year of experience OR
   d. 2 years of experience in a human service field.

5. Activities Coordinator: Job responsibilities of the staff member(s) providing activities coordination shall include but are not limited to developing and implementing therapeutic activities for both individuals and groups, contributing to assessments and plans of service, and documentation of services provided.

   The activities coordinator shall have the following minimum qualifications:
   a. Activity Consultant Certified (ACC) or
   b. Activity Director Certified (ADC) by the National Certification Council of Activities Professionals (NCCAP) OR
   c. Have a Bachelor Degree in a related field and one year of experience in developing and conducting activities for the population to be served at the center OR
   d. comparable technical and human service training with demonstrated competence and experience in developing and conducting activities for the population to be served at the center.

6. Direct Care Worker: The job responsibilities of a personal care attendant shall include assisting with and supervision of Activities of Daily Living (ADLs) in a safe and hygienic manner; with recognition of participants' dignity and right to privacy; and in a manner that encourages the maximum level of independence. (ADLs include bathing, dressing, eating, toileting, transferring, and mobility.)

   The adult day center shall set minimum qualifications for direct care workers.

C. Staff Presence

1. Definitions of staff

   b. Administrative staff are those staff who are not actively involved with the participants, are not immediately available to meet participants' needs, but who do provide resources and support to direct service staff, and who may or may not work on site.
   c. Direct service staff are those staff who work on site, are actively involved with the participants, and are-immediately available to meet participants' needs.
   d. Dual-role staff are those staff who provide direct services to participants as well as provide resources and support to direct service staff.

2. Staff-participant ratio

   a. During hours of operation, there shall be a sufficient number of responsible persons to safely meet the needs of those participants present, including one full or part-time staff member. The direct services staff-participant ratio shall be a minimum of one to seven.

   b. As the number of participants with functional or cognitive impairments increases or the severity of the impairment increases, the direct services staff-

      participant ratio shall be adjusted accordingly to meet the needs of the participants.

   c. Paid program consultants and contractors, persons working under agency contract, and volunteers may be included in the direct staff-participant ratio only when they are performing the direct service job tasks and responsibilities defined in a job description and meet the qualifications necessary to fill that position.

3. On-site oversight: A qualified staff member shall be designated to oversee operations of the center in the absence of the person responsible for administration/program coordination.

D. Adult day staff dedication in a shared space

1. Any adult day center that shares a building or space with another type of program or service (e.g., senior center) shall have dedicated staff with hours that are committed to the adult day center only.

2. Documentation shall be kept to verify which staff are committed to the adult day center and how many hours they work in the adult day center on a daily basis.

E. Paid Program Consultants or Contractors

The adult day center shall assure that all paid consultant or contractors providing direct participant services have been screened by the center for appropriate qualifications and in accordance with the Department's Background Check Policy.

1. Designated center staff shall oversee the services provided to participants in the course of their work with the center.

2. Centers are encouraged to maintain a written contract or letter of agreement on: file at the center for each paid contractor or consultant.

F. Agency Contracts

The adult day center shall maintain a written contract on file at the center with each agency in which at least the following components are included:

1. Responsibilities and/or services to be provided.

2. A statement indicating the estimated time commitment (hours/week, duration) as applicable.

3. Assurance that the agency shall provide persons with the appropriate qualifications or licensure to provide the services outlined in the written contract.
4. Designation of the responsibility for the following to either the agency or the adult day center including compliance with all required Agency of Human Services policies and completion of background checks in accordance with Departmental policy.

VI. Personnel Administration

A. Written personnel policies shall be adopted and shall be on file at the adult day center.

B. Documentation shall be on file at the center showing that all staff currently meets the minimum qualifications needed to qualify for their jobs.

C. An adult day center shall comply with the mandated reporting of abuse, neglect, and exploitation pursuant to Vermont State Law.

D. The center shall adhere to the Department's Background Check Policy for all individuals who provide direct care to participants. This includes but is not limited

to:

1. Persons employed full-time or part-time by the adult day center.

2. Paid consultants or contractors who provide direct services to participants.

3. Persons working under agency contract who provide direct services to participants.

4. Volunteers who provide unsupervised direct participant services.

E. Orientation Policy

1. An orientation policy shall be developed and implemented for the following:

   a. Persons employed full-time or part-time by the adult day center.

   b. Paid consultants or contractors who provide direct services to participants.

   c. Persons working under agency contract who provide direct services to participants.

   d. Volunteers who provide unsupervised direct participant services.

2. Documentation of orientation training provided to the individuals listed above shall be on file at the adult day center.

F. Training Policy

1. A training policy shall be developed and implemented for all persons employed full-time or part-time by the adult day center. Staff shall possess skills, education,
   and experience to serve the population in a manner consistent with the philosophy of the adult day center.

2. Amount of staff training

   a. For each direct service staff; a center shall assure a minimum of 12 hours of training per year that will builds his/her capacity to provide quality adult day services.

   b. For administrative staff; a center shall provide training as necessary.

   c. For each dual-role staff; a center shall assure a minimum of

12 hours of training per year and additional administrative training as necessary.

3. Documentation of staff training shall be kept on file at the adult day center to verify the topic, the number of hours, and the attendance.

VII. Program Policies

An adult day center shall comply with all applicable State and Federal laws and regulations, including all applicable Vermont State Agency of Human Services policies. In addition, an adult day center shall develop, implement, and have the following policies on file at the center reflecting current practice. If the adult day center is part of a larger organization, adult day specific policies shall be in place. These policies shall be made available to the public upon request.

A. Smoking Policy: Smoking by staff and participants shall not be allowed in any buildings where participants might go. The center shall establish a smoking policy for staff and participants that is in accordance with Vermont state law. This policy shall take into account the safety of both the participant who smokes and those who do not as well as agency staff and be posted in a public place in the adult day center.

B. Infection Control Policy: An infection control policy that outlines how the center will provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection, including blood borne pathogens and using universal precautions.

C. Emergency Evacuation Plan: An emergency evacuation plan shall be posted in a public place in the adult day center

D. Conflict of Interest Policy: Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. The policy shall include how participants or their representatives may report a concern regarding conflict of interest.

E. Records Retention Policy.

F. Confidentiality Policy: A policy regarding the confidentiality of participant records and protected health information.

G. Visitor policy. A policy that complies with a participant's right to have visitors at any time and describes the process for potential modifications to said participant's rights.

VIII. Participant Policies

An adult day center shall comply with all applicable State and Federal laws and regulations, including all applicable Vermont State Agency of Human Services policies. In addition, an adult day center shall develop, implement, and have the following policies on file at the center reflecting current practice. The policies in this section and any subsequent revisions made to them shall be submitted to and approved by the Department. Upon enrollment, every participant and/or his/her family member/caregiver/legal representative shall be informed of and provided a copy of all of the policies in this section in a format and language they can understand. A signed acknowledgement of the receipt of these policies shall be on file in each participant's file at the adult day center. These policies shall be made available to the public upon request.

A. Non-discrimination Policy: A non-discrimination policy shall state that no individual shall be excluded from participation in or be denied the benefits of the adult day center by reason of age, disability, race, gender, sexual orientation, religion, or national origin.

B. Participant Rights Policy: A participant's rights policy shall include, but not be limited to, the rights outlined in this section. A participant bill of rights shall be posted conspicuously in a public place in the adult day center.

1. The right to be treated as an adult, with respect and dignity.

2. The right to direct their person-centered plan to the maximum extent possible and to choose who may be included in that process.

3. The right to participate in a program of services and activities that promotes positive attitudes about one's usefulness and capabilities.

4. The right to participate in a program of services designed to encourage learning, growth and awareness of constructive ways to develop one's interests and talents.

5. The right to be encouraged and supported in maintaining one's independence to the extent that conditions and personal circumstances permit, and to be involved in a program of services designed to promote personal independence.

6. The right to be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided in accordance with the individual plan of service.

7. The right to privacy and confidentiality.

8. The right to have visitors at any time.

9. The right to be free from chemical restraints and unnecessary mechanical restraints.

10. The right to self-determination to the maximum extent possible through informed consent.

    a. Self-determination is defined as a participant's right to choose the lifestyle, residence, medical care, and support services which best meet his/her individual needs and wishes.

    b. Informed consent is defined as a process by which a participant or a participant's legal representative makes choices or decisions; including the right to accept or refuse services.

        i. An adult day center shall support the participant or the legal representative in making choices or decisions by providing information about the possible options, and the potential consequences of these options.
        ii. If the Adult Day is taking direction from a legal representative, there must be a copy of the legal documentation in the individual's file, (e.g. Guardianship or Power of Attorney documents).
        iii. To participate in this process, the participant and (or the participant's legal representative must understand the potential consequences of the decision, free from any coercion, and fully informed about the options and their potential consequences.
        iv. When a participant is capable of making informed choices, an adult day center shall support his/her right to be involved in decisions about the types and volumes of services he/she will receive.

C. Enrollment Policy: An enrollment policy shall include the following:

    1. Participant eligibility criteria.

    2. Prioritization Policy

        a. The prioritization policy shall describe how a center will prioritize requests for hours of service from new enrollees and/or to enrolled participants who have requested additional hours.

        b. Adult day centers shall make every reasonable effort to serve first those applicants most at risk of institutionalization, while balancing the needs of other participants and the ability of the center to meet the applicant's needs.

c. The prioritization policy may not discriminate based on age, disability, race, gender, sexual orientation, religion, or national origin. (See non-discrimination policy in section A above.)

d. Maintain a waiting list as appropriate, including the date of placement on the waiting list and anticipated source of reimbursement.

3. Procedure for enrolling a new participant.

D. Advance Directives Policy: An advance directive policy shall state that, upon admission, an adult day center will explain the participant's right under state law to formulate, or not to formulate, an advance directive.

E. Medical Emergency Policy: A medical emergency policy shall be posted in a prominent place which is readily visible to staff. The medical emergency policy shall include:

1. The requirement to call 911 in case of a medical emergency for all individuals who do not have a Do Not Resuscitate (DNR) document on file with the Center

2. The requirement for the center to have a portable basic emergency information sheet and release of information for the hospital and ambulance on file for each participant that includes a physician's DNR order or Clinician's Orders for Life Sustaining Treatment (COLST) form, as appropriate.

3. The requirement that the portable basic emergency information sheet should contain an identifying photo, a release of information for the hospital and ambulance shall accompany each participant when s/he leaves the center for any reason, including but not limited to a trip to the hospital or any center-sponsored event.

F. Medication Management Policy: An adult day center shall have the capacity to administer medications to their participants. A medication management policy shall describe a center's medication management practices with due regard for state requirements including the Vermont State Nurse Practice Act. At a minimum, the policy shall cover the following:

1. Staff shall only assist with or administer prescription medication or over-the- counter pain medication for which there is a physician's written order. For the
first day a participant is at the center, staff may administer medication on the basis of a documented verbal order from the prescribing provider given to a qualified nursing staff member of the center. The center staff may not continue

to administer medication based on a verbal order without a written order for longer than one calendar week.

2. An adult day center shall provide medication management under the supervision of a registered nurse or a licensed practical nurse under the direction of a registered nurse.

3. An adult day center shall ensure that a participant's medications are reviewed by a registered nurse upon enrollment, every six months, or more frequently as significant changes occur to ensure that all participant medications have either a supporting diagnosis or health problem.

4. All medicines shall be labeled in accordance with currently accepted professional standards of practice.
5. A participant may self-administer medication; however, the medication must be stored by the adult day center.

6. All prescription and over the counter pain medications that participants bring to the program are:

    a. Stored in an area specifically designated for medications.

    b. Stored in a secure area

    c. Stored in an area separate from the program's activity areas.

    d. Stored in an area that has appropriate temperature control.

7. An adult day center shall have written procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.

8. If a participant requires medication administration, unlicensed staff may administer medications under the following conditions:

    a. There is a physician's written order on file.

    b. A registered nurse has conducted a nursing assessment.

    c. A registered nurse or a licensed practical nurse under the direction of a registered nurse has properly documented the delegation of administration of specific medications to designated staff for designated participants.

    d. A registered nurse or a licensed practical nurse under the direction of a registered nurse retains responsibility for the

proper administration of medications, including:

i. Teaching designated staff proper techniques for medication administration and documentation and providing appropriate information about the participant's condition, relevant medications, and potential side effects.

ii. Establishing a process for routine communication with designated staff about the participant's condition and the effect of medications, as well as changes in medications.

iii. Assessing the participant's response to the medication and communicating with the medical personnel responsible for prescribing the medication as appropriate.

iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

9. An adult day center shall establish procedures for documentation of medication. At a minimum, this shall include:

a. Documentation of the medication administration task that has been delegated and the training provided by a registered nurse or an LPN working under the direction of a Registered Nurse to an unlicensed staff member for a particular participant, including the signatures of The LPN, and/or the Registered Nurse and the unlicensed staff member to whom the task has been delegated.

b. Documentation of all medications administered, signature of the individual administering the medication, and (if applicable) interventions taken to prevent adverse outcomes.

c. Documentation of all instances of refusal of medications.

d. Documentation of all incidents of medication errors and interventions taken to prevent adverse outcomes.

G. Restraint Policy: A restraint policy shall acknowledge the participant's right to be free from restraints and define the rare circumstances in which an adult day center would use mechanical or chemical restraints. The policy shall include regular review of any restraints and the right of the individual to appeal their use via the center's grievance procedures. The policy also shall be in compliance with Vermont's adult abuse statute, citation 33V.S.A. section 6911 in accordance with Vermont State Law.

1. When any restraints are used, the center shall document

a. The reason(s) for their use.

b. The fact that the participant is monitored on a regular basis to assure

i. The participant is safe in the restraints and

ii. The restraint is still necessary.

2. If a chemical restraint is used as a PRN to address behavioral issues, the center must also include in the participant's record a plan developed in advance describing the circumstances that will lead to the administration of the medication.

H. Critical Incident Policy: A critical incident policy shall include, but is not limited to:

1. Identification of critical incidents, including, but not limited to:

a. Events that adversely affect a participant's physical or emotional well- being.

b. Alleged cases of abuse, neglect, or exploitation.

2. Prompt reporting of such incidents to:

a. An identified person(s) within the adult day center

b. Family member/caregiver/legal representative as appropriate.

c. Adult Protective Services or the Department of Children and Families as appropriate.

3. Recording the essential facts of the incident, including the results of the incident and any actions which might have prevented the incident.

4. Establishing an action plan that includes the adult day center's immediate effort to address the incident and the long-term effort to reduce risk in the future.

5. Reporting of critical incidents to the Department in a timely and thorough manner as may be prescribed by the Department as defined by the Department critical incident policy. This will include notification to the Department.

I. Emergency Closing Policy: An emergency closing policy shall outline how the adult day center will announce and/or contact participants when the center closes due to bad weather, emergency situations, etc.

J. Grievance Policy: A grievance policy for resolving participants' concerns or complaints, including conflict of interest, shall adhere to procedures appropriate to the consumer's funding source* and include, but not be limited to:

1. Process and time frames for each step of the grievance process, including a final appeal to the Board of Directors.

2. Responses to participants' grievances shall be made in writing.

3. A written record shall be kept on each grievance.

*Note that Choice for Care, Day Health and Rehabilitation Services and the Veterans Administration may have different grievance policies.

K. Involuntary Discharge Policy: Involuntary discharge of a participant is the cessation of adult day services when the participant or the participant's family member/caregiver/legal representative has not requested or consented in advance to the cessation. An involuntary discharge policy shall include, but not be limited to:

1. An involuntary discharge may occur only when:

   a. The participant's care needs exceed those which an adult day center is certified to provide; or

   b. An adult day center is unable to meet the participant's assessed needs; or

   c. The participant presents a threat to self or to other participants or staff; or

   d. The participant has failed to pay for services in accordance with his/her signed billing agreement.

   e. The participant has not paid his or her patient share obligation to the center when it is owed to the center.

2. In the case of an involuntary discharge, an adult day center shall notify the participant and/or a family member/caregiver/legal representative and the Department of the specific reasons for the discharge in writing at least thirty (30) days prior to the discharge;

   a. Include a statement that the participant may appeal a center's decision to the Department within fifteen (15) days of written notification;

   b. Include a statement in the written notice that the participant may continue to attend the adult day center during the appeal; and

c. Include a copy of the center's grievance policy in a format they can understand.

d. Include the name, address, and phone number of the Vermont Senior Citizens Law Project or Vermont Protection and Advocacy or the Disability Law Project, as appropriate to the participant being involuntarily discharged.

3. An immediate involuntary discharge with less than a thirty (30) day written notice may occur only when:

   a. The participant's physician documents that the involuntary discharge is an emergency measure necessary for the health and safety of the participant or other participants; or

   b. A natural disaster or emergency necessitates the evacuation of participants from the center; or

   c. The participant presents an immediate threat to the health or safety of self or others.

4. In any case of immediate involuntary discharge, the adult day center shall:

   a. Notify the Department on the same or next business day.

   b. Notify the participant and/or a family member/caregiver/legal representative of the specific reasons for the discharge in writing on the same or next business day.

      i. Include a statement that the participant may appeal a center's decision to the Department of Disabilities, Aging and Independent Living within fifteen (15) days of written notification; and

      ii. Include a copy of the center's grievance policy in a format they can understand.

      iii. Include the name, address, and phone number of the Vermont Senior Citizens Law Project or Vermont Protection and Advocacy or the Disability Law Project, as appropriate to the participant being involuntarily discharged.

IX. Participant Records

A. Upon written or oral request, a complete copy of the contents of a participant's file, including archived material, shall be made available for review to the participant and/or the person(s) designated by the participant or his/her legal representative. Current records shall be made available within three (3) working days. Archived materials shall be made available within 10 working days.

B. Complete participant files shall be made available to Department staff upon written or oral request. This shall include archived materials, if requested.

C. All contents of a participant's file shall be typed or legibly handwritten in ink, dated, with the. name of the recording person with his/her title indicated. Electronic signatures by staff are acceptable for all documentation as long they clearly indicate who created the document and when it was created.

D. The adult day center shall maintain records for each participant that include, but are not limited to, the following:

1. Intake: An intake form shall be completed with the participant and/or a family member/caregiver/legal representative prior to the participant attending the

   center. The intake form shall include enough information about the participant to ensure that the program can safely and appropriately meet his/her needs while at the adult day center. The intake form may be the center's form or the form designated by the Department.

2. Medical information:

   a. If a participant has a physician or a primary care provider, the center shall submit a written request asking for a report reflecting the current health status of the participant within thirty (30) days of the start of adult day services and shall include, but not be limited to, the following:
      i. Findings or diagnosis, including communicable diseases.
      ii. Dietary needs.
      iii. Physician orders for treatments.
      iv. Medications.
      v. Allergies.
      vi. Immunization record; if available record to include tetanus and flu shot information.

vii. Discharge summary, if the individual has been hospitalized within the last three (3) months, if available.

b. The written request for a follow-up report shall be resubmitted to the physician or primary care provider within thirty (30) days of the anniversary of the initial report, and more frequently as significant changes occur.

3. Signed receipt of policies: A signed acknowledgement of receipt of the policies outlined in Section X.

4. Assessment: The assessment form designated by the Department shall be completed for each participant at reasonable times and locations of convenience to the individual Additional assessment data may be collected as appropriate to gain a thorough understanding of the participant.

   a. Initial assessments shall be completed within the first thirty (30) sessions of participation at the adult day center or within ninety (90) days of enrollment, whichever occurs first.

   b. Reassessments shall be completed within thirty (30) days of the anniversary of the initial assessment, and whenever significant changes occur.

   c. The health section of the assessment may only be completed by a registered nurse (RN) or a licensed practical nurse (LPN). The health section must be signed by the RN who completed it. If an LPN completed the health section, a RN must review and sign it.

5. Plan of Service: The process for developing the adult day plan of service is an inclusive, person-centered process that enables the adult day center to serve the participant to the best of its ability. The initial plan of service shall be written within ninety (90) days of the beginning of adult day services and shall include:

   a. Focus Areas: The focus areas are those areas of the assessment in which issues have been identified that need to be addressed with written goals.

   b. Goals: Goals describe the participant-centered outcome(s) that will be achieved because service is provided. Whenever possible, goals shall be stated in measurable terms.

   c. Actions: Actions describe the activities the staff or others (including the participant) will carry out to assist the participant and/or family

member/caregiver to achieve the goals.

6. Six-month Review Verification: Documentation that a review of each participant's assessment, plan of service, and progress notes has occurred at least once every six months.

7. Modifications: Modifications are any person-specific exceptions to the required person-centered planning process and participant rights. (see section X.B.) Modifications must:

   a. Identify a specific and individualized assessed need for modification

   b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan

   c. Document less intrusive methods of meeting the need that have been tried but did not work

   d. Include a clear description of the condition that is directly proportionate to the specific assessed need

   e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification

   f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated

   g. Include informed consent of the individual

   h. Include an assurance that interventions and supports will cause no harm to the individual

8. Monthly Progress Notes: At a minimum, a monthly progress note shall be maintained and shall:

   a. reflect a review of the entire adult day Plan of Service

   b. contain narrative notes reflecting any relevant information such as progress, changes in goals or discontinuances of goals, and

   c. document the ongoing effectiveness of any modifications to the person-centered plan.

9. End of Service: As appropriate, an adult day center shall arrange for the

participant to receive services from other organizations, whether a voluntary or involuntary discharge at the end of service. The adult day center shall consult with and obtain permission from the participant and/or the family member/caregiver/legal representative before making appropriate community service referral(s). The adult day center shall document any end of service plans made for the participant.

10. Permission to Release Information: Completed permission for release of information using the form authorized by the Department.

    a. The permission for release of information shall be signed and dated by the participant or his/her family member/caregiver/legal representative within thirty (30) days of the start of adult day services, (or sooner if needed) on the same schedule as the assessment.

    b. The permission for release of information shall be signed and dated annually, within thirty (30) days of the anniversary of the initial review, on the same schedule as the assessment.

11. Attendance: Accurate and complete documentation of daily attend
    a. Daily attendance records shall document:
        i. The date of attendance

        ii. The accurate time in and time out for each participant. The time in and time out may be rounded up or down to the nearest quarter hour.

        iii. Daily attendance does not include time spent during transportation to or from the center.

    b. Billing records shall reflect attendance as shown by the dates and units of attendance on the daily attendance records and shall comply with the attendance limits approved by the funding source.

12. Funding Sources: All documentation as required by all applicable funding sources.

13. Variances: Any variance requests made to the Department, including the Department's response.

14. Correspondence: Correspondence with family members, caregivers, legal representatives, or other community agencies/primary care providers.

15. Incident Reports: Incident reports as indicated by the center's and the Department's policies.

16. Termination Notices. Notices and documentation related to termination of services.

X. Adult Day Services

Based on an established method for assessing the needs, competencies, abilities and interests of participants, a number of therapeutic activities and services shall be provided.

a. Health Coordination & Chronic Disease Management: A service provided to each participant and monitored by the staff RN and includes:
   i. A written health assessment
   ii. Development of a written plan of service for each participant that is based on abilities and needs as identified in the assessment, evaluating and documenting the ongoing services provided for each participant,
   iii. Health monitoring
   iv. Health education
   v. Instruction and supervision to all direct care staff regarding each participant's health care needs and nutritional needs,
   vi. Delegating nursing tasks as appropriate, and practices according to the standards for registered nurses as identified in the Vermont Nurse Practices Act.
   vii. Provision of health oversight and activities that help participants and families to understand chronic diseases and health conditions. This involves encouraging participation in activities and interventions to achieve an ongoing, reasonable quality of life.
   viii. Depending on the level of need, health education and counseling shall be provided or arranged for at different levels of intensity for participants and/or their family members/caregivers/legal representatives.

b. Direct Care: Assistance with and supervision of activities of daily living (ADL), supervised by an RN and/or LPN. Direct care is provided in a safe and hygienic manner; with recognition of participants' dignity and right to privacy; and in a manner that encourages the maximum level of independence. ADLs include bathing, dressing, eating, toileting, transferring, and mobility.

c. Social Work Services: Support provided by a qualified professional to participants and their family/caregivers/legal representatives including:
   1. assisted in learning about and accessing community resources for financial, social, personal, recreational, advocacy, educational, health, caregiver support, and other services,
   2. discharge planning, and
   3. documentation of services provided.

d. Therapeutic Activities: Services coordinated and supervised by a qualified professional, including developing and implementing therapeutic activities for both individuals and groups, contributing to assessments and plans of service, and documentation of services provided intended to, remediate or prevent functional impairments, enhance

function, reduce individual risk factors, and optimize overall health, fitness & well-being.

Activities shall be provided in the following manner:

1. Program activities shall be available to all program participants,
2. A structured program plan of activities shall be available and posted daily to assist with orientation.
3. Participants shall be encouraged to take part in activities, but may choose not to do so or may choose another activity.
4. Participants shall be allowed time for rest and relaxation and to attend to personal and health care needs.
5. Activity programming shall be available during all hours of operation.
6. Programming shall take into consideration individual differences in age, health status, sensory deficits, life-style, ethnicity, religious affiliation, values, experiences, needs, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.
7. Programing shall provide a balance of purposeful activities to meet the participants' interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual).
8. Programming shall be designed to promote personal growth and enhance the self-image and/or to improve or maintain the functioning level of the participants to the extent possible within the setting.
9. The environment shall be conducive to facilitating activities and participants shall be assisted in maintaining maximum mobility and independence.

e. Nutrition & Food Services: At least one meal must be offered per day. Each meal must meet at least one third of the Recommended Daily Allowance (RDA) established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines of America and safe food handling and storage standards. See detailed standards in section XII.

f. Transportation: When feasible, the center shall provide, formally arrange or contract for transportation to enable participants to attend the center.

XI. Nutrition and Food Services

An adult day center shall plan menus and prepare food according to the nutrition and food service standards outlined below.

a. Monthly Menus

i. When meal preparation occurs on-site, monthly menus shall be planned, written and posted at least one (1) week prior to the first of the month, or sooner as necessary in order to have the food supplies ordered and available

to produce the menu as written.

ii. Menus shall be reviewed by a Dietician unless the center is enrolled in the Child and Adult Care Food Program which emanates from the Department of Education, or has Veterans Administration certification or receives meals from the Meals on Wheels program.

3. When meals are catered, the monthly menu shall be planned, written and posted at least one (1) week prior to the first of the month.

4. The current monthly menu shall be posted in a place accessible and visible to all participants and other interested parties.

5. The center shall follow the written, posted menus. If a substitution must be made, the substitution shall be recorded on the primary menu on file or a menu substitution sheet.

6. The center shall keep menus, including any substitutions, for the previous 12 months on file and have them available for review by any authorized state official.

b. Nutritional Standards

i. Each meal served must provide at least one-third of the Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences **and** comply with the Dietary Guidelines for Americans.

ii. Special diets shall be accommodated.

iii. Sufficient food supplies: A plan for emergency food service shall include three days of non-perishable supplies shall be on hand.

C. Suggested Meal Plan

The guide included in Appendix A provides the basis for meal planning. Meals planned according to this guide will help ensure that menus meet the standards as outlined in Section XII. A & B. In cases of a participants advanced age and very light activity, centers may consider individual needs with respect to portion size and frequency of eating but shall not compromise overall nutrient intake. In addition to the suggested food servings, fluids shall be encouraged throughout the day.

D. Food Service

1. Each center shall provide participants with nutritionally balanced, attractive

and satisfying meals in accordance with these standards. Meals shall be served at the appropriate temperature and at normal meal hours. Texture modifications will be accommodated as needed.

2. Nourishing snacks shall be available to participants between meals.

3. Participants shall be allowed an adequate amount of time to eat each meal at an unhurried pace.

4. Participants shall be encouraged to feed themselves, using adaptive equipment (utensil, dishes) where appropriate.

5. Participants shall be provided with assistance in eating, as needed, by properly trained staff.

6. Participants shall be offered an alternative to the planned meal upon request. The adult day center shall determine what can be reasonably accommodated.

E. Safe Food Handling

1. Each center shall procure food from sources that comply with all laws relating to food and food labeling. Food shall be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation shall be pasteurized. Cans that are outdated or have dents, swelling or leaks shall be rejected and kept separate until returned to the supplier.

2. All perishable food and drink shall be labeled, dated and held at proper temperatures:

   a. At or below 40 degrees Fahrenheit.

   b. At or above 140 degrees Fahrenheit when served or heated prior to service.

3. All work surfaces shall be cleaned and sanitized after each use. Equipment and utensils shall be cleaned and sanitized after each use and stored properly.

4. The center shall ensure that food handling and storage techniques are consistent with safe food handling practices.

F. Food Storage and Equipment

1. All food and drink shall be stored so as to protect it from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of

contamination.

2. Areas of the center's building used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean.

3. All food service equipment shall be kept clean. and maintained according to manufacturer's guidelines.

4. All equipment, utensils and dinnerware shall be in good repair. Cracked or badly chipped dishes and glassware shall not be used.

5. Single service items, such as paper cups, plates and straws, shall be used only once. They shall be purchased and stored in sanitary packages or containers in a clean dry place and handled in a sanitary manner.

6. Access to the kitchen shall be limited to individuals involved with the food service. Exceptions may be granted at the discretion of the food service manager.

7. Doors, windows and other openings to the outdoors shall be screened against insects, as required by seasonal conditions.

8. All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers.

9. Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area.

XII. Facility

A. Primary Adult Day Center Sites

1. A primary adult day center site is the identified main site for the adult day provider organization that provides the full range of services and hours of operation in a given region.

2. Adult day services shall be offered to participants at a minimum of five (5) days per week, nine (9) hours per day at the primary adult day center site.

B. Satellite Adult Day Center Sites

1. For any current Adult Day provider wishing to obtain state certification and to receive either State or federal funding, a written request shall be submitted to the Department seeking approval to operate any satellite locations prior to opening and providing adult day services.

2. Prior to opening and providing adult day services, an adult day center shall demonstrate that the proposed satellite operation is in compliance with the Standards for Adult Day Services in Vermont including standards around unmet needs (II.A.2 and 3).

C. Accessibility

Certified adult day centers shall be designed or remodeled to accommodate individuals in conformance with the requirements of Section 504 of the Rehabilitation Act of 1973, and 28 CPR, Part 36 implementing Title III of the Americans with Disabilities Act, P.L. 101-336, and any applicable Vermont or local accessibility requirements.

D. Renovations & Additions

Prior to making renovations or additions that will involve structural changes, the adult day center shall:

1. Consult the Department.

2. Obtain all necessary town, city, or state permits (including the Department of Labor and Industry) prior to structural renovations or additions being made or obtain documentation stating that approval of the work is not necessary **and** have one of the documents available for review.

E. Health and Safety

1. The adult day center's building shall be designed, constructed and maintained in compliance with all applicable health and safety laws and regulations.

2. There shall be sufficient personnel working on a regular schedule and in conformity with generally accepted standards to ensure that the building is clean, sanitary and safe at all times.

3. Certified adult day centers shall meet all of the applicable fire safety and building requirements of the Department of Public Safety and shall be inspected annually.

   a. For those adult day centers that are inspected annually by the

Department of Veterans Affairs for Life Safety Code compliance, that survey will be accepted as the annual review as long as a copy of the review (and, as necessary, an accepted plan of corrective action) is provided to the Department. Those centers that are inspected by the Department of Veterans Affairs but that inspection occurs less than annually shall demonstrate their meeting of this standard through the procedures described in parts b. or c. of this section.

b. For those adult day centers that undergo a comprehensive health and safety inspection annually by another public review entity, that survey will be accepted as the annual review as long as a copy of the review (and, as necessary, an accepted plan of corrective action) is provided to the Department.

c. For those adult day centers not already being inspected in one of the two ways outlined above, a current completion of the Center's own safety checklist shall meet the requirements of this section.

F. Environment

1. A center shall have a sign outside clearly identifying the name of the adult day center.

2. An adult day center shall be designed and furnished with consideration for the special needs and interests of the people to be served and the activities and services to be provided.
3. Lighting in all areas shall be adequate to support the safety of participants and facilitate the activities of the program.

4. Noise levels shall be controlled.

5. Heating, cooling and ventilation system(s) shall afford comfortable conditions for participants.

6. There shall be sufficient furniture to accommodate the needs of all participants. Furniture and equipment to be used by participants shall be selected both for comfort and safety, and to enhance personal independence of participants.

7. Where possible, a covering shall be provided over one outside entrance to protect participants from inclement weather.

8. A telephone shall be available for participants.

9. The center shall make arrangements as necessary for the security of the participants and their possessions in the facility.

I 0. When necessary, arrangements shall be made with local authorities to provide safety zones for those arriving by motor vehicles and adequate traffic signals for pedestrian crossing

11. Emergency first-aid kits shall be available in the program area.

G. Location and Space

1. In addition to complying with all applicable building codes and zoning requirements, the selection of a site shall be based, to the extent possible, on the needs of potential participants, and shall include consideration of the following factors:

   a. Demographic information and projections

   b. Greatest accessibility to the communities from which participants are drawn

   c. Proximity to other services and facilities

   d. Convenience of public or private transportation

   e. Safety and security of participants and staff.

2. When possible, the center shall be located at ground level.

3. An adult day center may share a facility with another type of program or service (e.g. senior center), however the adult day center is required to have separate program space.

4. The center shall have sufficient space to accommodate the full range of programs activities and services including:

   a. At least sixty (60) square feet of program space for each participant.
      i. It is strongly recommended that centers serving a significant number of people with cognitive impairments or those who use adaptive equipment for ambulation or medical care provide eighty to one hundred (80 – 100) square feet per participant.
      ii. In determining adequate square footage, only those activity areas commonly used by participants are to be included. Dining and kitchen areas are to be included only if those areas are used by participants for activities other than meals. Reception areas, storage areas, offices, restrooms, passageways, treatment rooms, service areas, or specialized spaces used only for therapies are not to be included when calculating square footage.

b. Sufficient flexibility and adaptability for large and small groups, and for individual activities and services.

c. Sufficient private office space to permit staff to work effectively and without interruption.

d. Adequate storage space.

e. At least one toilet for every 10 participants, easily accessible from all areas.

£ Areas separate from program space that provides sufficient space for a rest area, for special therapies, for privacy, and for isolating participants who become ill.

g. A sufficient parking area for the safe daily arrival and departure of participants.

h. Outdoor space that is used for outdoor activities that is safe, accessible to indoor areas, and accessible to those with a disability.

i. Adequate space (such as closets and separate lockers), for outer garments and private possessions.

j. Adequate dining, kitchen and storage space shall be available for meal and snack service as outlined in Section XI.

XIII. Variances

An adult day center may request a variance to any of these standards by contacting the Department.

a. A variance may be granted if:

i. Strict compliance would impose a substantial hardship on the participants or the service providers.

ii. The goal of the standard will otherwise be met.

iii. The variance will not result in less protection of the health, safety, and welfare of the participant.

iv. The variance will be in compliance with applicable state and federal regulations.

b. The variance request shall include:

   i. The standard for which a variance is being requested.

   ii. An explanation of why the standard cannot be met by the center.

   iii. The extent to which the center will be able to meet the standard.

   iv. The timeline in which the center will come in to compliance with the standard, if applicable.

C. The Department shall respond in writing within sixty (60) days of receiving the variance request.

Appendix

Recommended Daily Meal Patterns for Breakfast and Lunch/Supper

Food Group	Breakfast
Milk (cup)	3/4
Fruit or non-starchy vegetables (cup)	*Yi*
Grain/bread (oz. equivalent)	2
AND	
Lean meat or meat alternative (oz. equivalent)	1
OR	
Grain/bread (oz. equivalent)	3
Lean meat or meat alternative (oz. equivalent)	0

Lean meat or meat alternates should be served 3 days per week at breakfast. On each of the days without meat or meat alternates, serve an additional 1 oz equivalent of bread/grains.

Food Group	Lunch/Supper
Milk or yogurt (cup)	1
Fruit (cup)	*Yi*
Vegetable (cup)	1
Grain/bread (oz. equivalent)	2
Lean meat or meat alternative (oz.	2

At least half of the grain/bread must be whole grains. Other grain/bread must be enriched.

The number of cups indicated for vegetables represents the total served. Offer two different types of vegetables per meal. Serve dark green vegetables at least twice per week, orange vegetables at least twice per week, starchy vegetables no more than twice per week, and other vegetables at least three times per week.

Milk or yogurt: low fat. Yogurt with less than 17 grams of total sugar per 1 cup serving.

Fruit: apples, apricots, avocado, bananas, blueberries, cantaloupe, cherries, fruit cocktail, grapefruit, grapes, honeydew, kiwi fruit, mangoes, nectarines, oranges, peaches, pears, papaya, pineapple, plums, prunes, raisins, raspberries, strawberries, tangerines, watermelon

Dark green vegetables: Bok choy, broccoli, collard greens, dark green leafy lettuce, kale, mescaline, mustard greens, romaine lettuce, spinach, turnip greens, watercress.

Orange vegetables: Acorn squash, butternut squash, carrots, Hubbard squash, pumpkin, sweet potatoes.

Starchy vegetables: Corn, green peas, lima bean, potatoes.

Other vegetables: Artichokes, asparagus, bean sprouts (cooked or canned only), beets, Brussel sprouts, cabbage, cauliflower, celery, cucumbers, eggplant, green beans, green or red peppers, iceberg lettuce, mushrooms, okra, onions, parsnips, tomatoes, tomato juice, vegetable juice, turnips, wax beans, zucchini

VERMONT

Case Management Standards & Certification Procedures

Older Americans Act & Choices for Care Programs

Revised January 1, 2017

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I. INTRODUCTION

The Adult Services Division (ASD) within the Department of Disabilities, Aging and Independent Living (DAIL) recognizes that quality case management is a critical part of our long-term services and supports system and is crucial to the fulfillment of DAIL's mission. The mission of DAIL is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.

In order to ensure the statewide quality of case management services offered under Older Americans Act (OAA) programs and Choices for Care (CFC), ASD has instituted Case Management Standards and Certification Procedures. The purpose of this document is to establish minimum case management performance standards and to provide guidance for case management agencies and individual case managers. These standards and certification procedures apply to case management services offered under OAA programs and CFC. The Choices for Care Program Manual and Regulations provide more detailed policies and procedures specific to CFC.

DAIL authority to establish service standards and to certify providers of case management services under OAA programs and CFC is established in Vermont state statute, the Center for Medicare and Medicaid Services (CMS) approved Global Commitment to Health 1115 Waiver, and the Older Americans Act.

II. DEFINITIONS

A. **Case Management:** Case management is a professional service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes.

B. **Conflict of Interest:** Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of case management services must maintain a conflict of interest policy that is in line with the standards set by the Centers for Medicare and Medicaid (CMS). See Appendix A for a link to the CMS regulations.

C. **Home and Community-Based Services (HCBS):** HCBS services are person-centered services provided to an individual in their own home or in the home of another person. HCBS services assist individuals to maintain as much independence, community participation, freedom of choice and control over their lives as possible, while preventing the need to live in a licensed facility. The Centers for Medicare and Medicaid Services (CMS) regulates Medicaid funded HCBS services with regards to person-centered planning and settings characteristics.

D. **Modifications:** "Modifications" are any individual-specific exception to the person-centered planning process as required by the federal home and community-based services (HCBS) regulations. Modifications must be documented and include specific elements identified in Section IV. M.

E. **Person Centered Planning:** Person-centered planning is a process for supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning for HCBS services covered under Vermont's Choices for Care program and other similar HCBS long-term services and supports programs. See Appendix A for a link to the CMS regulations.

F. **Quality Management:** Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 124 and

the Vermont Government Accountability Office provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.

G. **Self-Neglect:** Self-neglect is an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs. This definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision (National Adult Protective Services Association).

III. AGENCY CASE MANAGEMENT STANDARDS

All agency policies governing case management activities under OAA and CFC programs listed in the section must be reviewed and approved by ASD. Changes made to the approved policies must be reviewed and approved by ASD prior to implementation.

Case management agencies are expected to be knowledgeable of and in compliance with all relevant state and federal laws and requirements. Case management agencies shall also ensure the requisite case management agency policies are in place, the case management agency is responsible to ensure that all case managers providing services under OAA and CFC programs comply with the ASD Case Management Standards & Certification Procedures and related case management agency policies.

Case management agencies shall have the following written policies and protocols:

A. **After Hour Coverage**: The protocol shall at a minimum ensure that people are able to leave a message with the agency when it is closed.

B. **Consumer Complaint and Grievance Policy**: The policies and procedures shall outline how the case management agency will respond to consumer complaints and grievances. The policies shall address how consumers are informed about agency policies, including the complaint and grievance policy, and will explain how the process works.

C. **Information and Referral Policy**: The policy shall state that the case management agency will accept and respond to requests for information and/or assistance from individuals, caregivers and other third parties.

D. **Mandated Reporting of Abuse, Neglect, and Exploitation Policy**: The policy shall address how the case management agency will respond in cases of suspected abuse, neglect, and/or exploitation of vulnerable adults. The policy must be consistent with the requirements of Vermont statute 33 V.S.A. § 6903 and DAIL policies. ASD shall coordinate review and approval of this policy with Vermont Adult Protective Services, at the Department's Division of Licensing & Protection.

E. **Self-Neglect Policy**: The policy shall define how the agency will serve adults identified as self-neglect. This may include a referral to the AAA (for adults age 60 and older) or the local Designated Agency (DA) for adult mental health services (for adults under the age of 60). In the case of CFC referrals, the case management agency selected by the person shall be responsible for serving the person identified as self-neglecting.

F. **Maximum Caseload Policy**: The policy shall state the maximum caseload size for case managers, the prioritization process for people accessing case management services, and the management of waiting lists for people who cannot be served at any given time.

G. **Case Management Supervision Policy**: The policy shall address how supervision is provided including accessibility of supervisors, review of client records, on-going feedback between the supervisor and case manager and timely performance evaluations of case managers.

H. **Orientation Training Policy**: The policy shall outline the orientation training for new case management staff.

I. **Training Policy**: The policy shall outline ongoing case management training designed to ensure that case managers will have the necessary range of knowledge, skills and abilities to provide high quality case management services.

J. **Quality Management Policy**: The policy shall outline the case management agency's ongoing Quality Management plan regarding case management services. (Refer to Section II. Definitions for a definition of Quality Management).

K. **Conflict of Interest Policy**: At a minimum, the policy shall: (Refer to Section II. Definitions for a definition of Conflict of Interest).
   1. Define conflict of interest,
   2. Describe the agency's process for preventing conflict of interest,
   3. Describe how case managers report potential conflicts of interest immediately with their supervisor,
   4. Describe the agency's process for correcting conflict of interest when it occurs.
   5. Describe that the case manager developing the person-centered plan shall not be any of the following:
      a. Related by blood or marriage to the individual or to the paid caregivers of the individual
      b. Financially responsible for the individual
      c. Empowered to make financial or health-related decision on behalf of the individual
      d. Holding financial interest in an entity that is paid to provide care for the individual
      e. Other limitations as set by CMS and in line with federal rules.

L. **Client Record Policy**: The policy shall include:
   1. The procedure governing their use, storage and removal.
   2. The conditions for release of information contained in the record.
   3. The requirements of authorization in writing by the person or legal representative for release of information.
   4. The maintenance of all records relating to the delivery and documentation of case management services for a minimum of 3 years and the maintenance of all financial records for a period of 7 years.
   5. Compliance with the Health Insurance Portability and Accountability Act.

M. **Background Check Policy**: The policy shall outline the background checks required in order for a person to be employed as a case manager. The policy must be

consistent with the DAIL Background Check Policy.

N. **Emergency Management Plan**: The agency shall have a plan describing how it will identify the critical functions and services it performs that must continue in the event of an emergency and include a plan as to how those functions and services will be provided during that time. The plan shall describe how the agency will collaborate and cooperate with local emergency planners and other local providers. The plan shall also describe how the agency will:

1. Identify persons who might require specific assistance during an emergency; and

2. Provide information and encourage people to develop a personal emergency preparedness plan. Provide assistance in developing the plan as necessary for needed assistance and support in the event of a natural or other emergency which may result in disruption of service and/or personal harm. Involvement and consideration of family caregivers, as well as other natural supports must be part of the process.

O. **Agency Confidentiality Policy**: The agency shall have a policy that is no less stringent than the Agency of Human Service Consumer Information and Privacy Rule.

P. **Smoking Policy**: Agency shall have a smoking policy that at a minimum prevents staff from smoking in the presence of people receiving services.

Q. **Limited English Proficiency Policy**: Agency shall have a policy that describes how people with limited English proficiency will be assured meaningful access to services provided by the agency. The policy must comply with federal regulations.

IV. INDIVIDUAL CASE MANAGER STANDARDS

A. The case manager must be knowledgeable of and comply with all agency policies and standards.

B. A case manager shall be knowledgeable about the full range of services available to individuals in their region and shall ensure that individuals are informed of available resources and services. The case manager will make any needed referrals.

C. A case manager shall provide service in an efficient, effective and collaborative manner to avoid duplication of services, unnecessary costs, and administrative tasks.

D. A case manager shall respond to requests for information and/or assistance from individuals in a timely manner.

E. A case manager shall inform all individuals of the agency's grievance procedures.

F. To the extent possible, a case manager shall ensure the person receives person-centered services in the least restrictive and most appropriate setting in accordance with his or her needs and preferences, as required by the U.S. Supreme Court Olmstead decision. (See Appendix A.)

G. A case manager shall recognize self-neglect behaviors and offer intervention, when such behaviors jeopardize the person's wellbeing. For people not enrolled in Choices for Care, a referral shall be made to the AAA (for adults age 60 and older) or the regional Designated Agency for adult mental health (for adults under age 60).

H. A case manager shall respect the person's rights, strengths, values and preferences, encouraging the individual to create, direct and participate in their individualized written person-centered plan to the fullest extent possible.

1. The person may involve a caregiver or a legal representative in decision making. A legal representative may be a legal guardian appointed by probate or family court with specific duties outlined in the court order, an attorney or power of attorney.

2. People have the right to make their own decisions and decide who they want to be involved in decision making. In the event that a person has a guardian or agent, the case manager will involve him/her in accordance with that individual's legal responsibility. When a person does not appear to have the capacity to make decisions and there is no legal guardian or agent the case manager shall refer to the agency policy on self-neglect.

3. The case manager will provide a person-centered process that is timely and occurs at times/locations of convenience to the individual.

4. Person-centered planning must reflect a process that the setting in which the individual resides is chosen by the individual.

5. A case manager shall ensure that a person has the right to receive services under conditions of acceptable risk. "Acceptable risk" is the level of risk an individual and/or his/her guardian, if there is one, is willing to accept after the informed consent process. A case manager may work with the individual and the service provider to develop a Negotiated Risk Agreement when necessary.

I. Assessment: A case manager, with input and participation by the person and his/her support network, shall assess the individual's strengths and needs using the assessment tool(s) approved by ASD.

1. A case manager shall update the assessment at least annually, or at any time there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed.

2. A case manager shall make every effort to assure the completeness and accuracy of the initial assessment and any subsequent reassessments.

3. Assessments need to be completed in compliance with Choices for Care and other program protocol.

J. Goals: When a person requires case management assistance for complex issues the case manager along with the individual and his or her support network shall identify person-centered goals.

K. Planning: Using the information from assessments and in consideration of the individual's person-centered goals, the case manager shall discuss all available options with the individual and his or her support network; and, agree upon strategies built upon the strengths of the individual to achieve these goals. Strategies shall describe the specific service or support to be provided, the person responsible for carrying out the strategies and the target date as agreed upon by the person. The initial goal and strategy identification shall be completed within 60 days of completion of the assessment.

L. Monitoring and reviewing: A case manager shall monitor the delivery of formal and informal services and supports to ensure that services are being provided as planned, to ensure that the person's identified needs are being met, and goals are being pursued. Monitoring shall include regular contact with the individual, caregivers, and service providers. The individuals' goals and strategies shall be updated to reflect the annual reassessment or more frequently if there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed. For more specific guidelines, refer to program and agency requirements.

M. Documentation: A case manager shall maintain current, complete and accurate paper or electronic files for each person including but not limited to:

1. A written release of information or documentation of why a written release of information could not be obtained.

2. The appropriate assessment form designated by DAIL.

3. Person-centered plan which is driven by the individual. The plan must:
   a. Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports the individual's strengths and preferences.
   b. Reflect the setting in which the individual resides is chosen by the individual.
   c. Reflect clinical and support needs as identified through an assessment of functional needs.
   d. Reflect individually identified goals and desired outcomes.
   e. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of paid services.
   f. Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
   g. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
   h. Identify the individual and/or entity responsible for monitoring the plan.
   i. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
   j. Be distributed to the individual and other people involved in the plan.
   k. Include those services, the purchase or control of which the individual elects to self-direct.
   l. Prevent the provision of unnecessary or inappropriate services and supports.

4. Modifications, or exceptions, to the CMS required HCBS person-centered planning process must be documented and include the following: (see definition of Modifications)
   a. Identify a specific and individualized assessed need for modification

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan
c. Document less intrusive methods of meeting the need that have been tried but did not work
d. Include a clear description of the condition that is directly proportionate to the specific assessed need
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
g. Include informed consent of the individual or their legal representative
h. Include an assurance that interventions and supports will cause no harm to the individual.

5. Case notes that shall focus on the individual's progress and any emergent issues that need to be addressed.

6. Other correspondence received or sent which is relevant to individual.

7. Other documents required by specific programs and services, such as copies of applications, notice of decisions, etc.

8. Guardianship/ Power of Attorney and other advanced directives must be documented in the assessment.

9. If the case manager is taking direction from a legal representative, there must be a copy of the legal documentation maintained in the individual's case management record. (e.g. Guardianship or Power of Attorney documents.)

10. Documentation of Negotiated Risk Agreement (if applicable).

11. Documentation of required reporting of suspected abuse, neglect and exploitation.

V. CERTIFICATION PROCESS

A. A case management agency is deemed certified for one to three years by the ASD when the following components have been met:

1. An Area Agency on Aging have a current approved area plan on file with the ASD ora Home Health Agency has received designation to provide Medicare home health services in the State of Vermont by Division of Licensing and Protection (DLP) through the designation or survey process.

2. ASD has completed a certification review.

3. The agency has demonstrated compliance with all requirements found in the Case Management Standards or has shown progress that is acceptable to ASD towards resolving unmet case management standards at time of initial certification or re-certification.

B. The ASD certification process includes:

1. Verification that an Area Agency on Aging has a current approved area plan on file with ASD or verification that a Home Health Agencies has received designation to provide Medicare home health services in the State of Vermont, by Division of Licensing and Protection (DLP) through the designation or survey process.

2. Approval of the policies required in the Case Management Standards.

   a. Policies shall be submitted to ASD in a manner which allows ASD to maintain an electronic file for each agency.

   b. Policies which have been approved as part of the AAA Area Plan process or as part of the Home Health Agency designation do not have to be resubmitted at the time of the initial or recertification process. (See Appendix D for a list of those policies which are included in the Agency on Aging Area Plan or Home Health designation process.)

   c. Policies relating to case management services which have been updated or altered since the previous certification review must be submitted to ASD for approval prior to the certification review process.

3. Review of complaints received and documented at ASD during the past year.

4. Consultation with the following community partners regarding the quality of case management services provided by the agency, as needed:
   - Adult Day providers
   - Waiver Team Members
   - Public Guardians

- Field Directors

5. An on-site review at the case management agency.

   a. Each agency will be notified of the review within one (1) week of the pending on- site visit. ASD reserves the right to make unannounced agency site visits with the intention to conduct a targeted review.

   b. The on-site portion of the review will last for three (3) days but may be extended at the discretion of ASD. It will include:
      - A review of individual CFC and/or OAA case management files.
      - Home-based interviews with individuals who receive case management services through CFC or OAA programs. Interviews may also include family members, surrogates and/or caregivers.
      - Individual interviews with case management staff.
      - Interviews with the Agency Director, Long Term Care Director, and/or Case Management Supervisor(s) to discuss the quality of case management services, the implementation of policies and procedures, and program understanding within the agency.
      - An exit interview with the agency director and others the director may choose to invite. This interview will summarize the preliminary findings of the review.

   c. The review sample will be limited to 4 to 6 individuals participating in High/Highest Needs CFC and/or OAA programs. The sample selection will be announced during day one of the review and may be expanded at the discretion of ASD. Records of other recipients of services may be reviewed as required.

   d. The discovery period of the review process will last no more than fourteen (14) consecutive days. This timeframe may be extended by mutual agreement between ASD and the agency.

   e. A written report addressing the results of the Certification Review will be available to the agency within thirty (30) days from the end of the review process.
      - The written report will consist of a brief letter which states the date of the review under discussion and the Review Grid completed by the DAIL reviewer at the time of the review.
      - A brief statement of particular areas of strength of the agency.
      - A statement of whether all of the Standards were met or not. If any area was not met, the letter will refer the reader to the Review Grid.
      - Any corrective action plan required from the agency must be received by ASD within 15 days from the date the agency received the ASD written report of the results of the quality review.

6. The final review report will have one of the following recommendations.

    a. Three-year certification: No corrective actions or recommendations.

    b. Two-year certification: Granted at the discretion of ASD if the agency's corrective action will bring an unmet standard into full compliance within a month of submittal to ASD.

    c. One-year certification: Granted at the discretion of ASD if the agency's corrective action plan will bring an unmet standard into full compliance after follow-up review visit(s).

    d. Suspension of certification: Granted at the discretion of ASD pending corrective action plan acceptance and follow- up review.

7. Certified Case Management agencies will be listed on the DAIL website. A redacted copy of the certification documents will be available to the public upon request.

8. The following documents will be used as technical references during the Certification Review process:
    a. Case Management Standards & Certification Procedures for Older Americans Act Programs and Choices for Care

    b. Case Manager Training Process

    c. Choices for Care High / Highest Needs Program Manual

    d. Older Americans Act and Accompanying Regulations

VI. APPEALS

The decision to suspend certification or to decertify may be appealed to the Commissioner of the Department of Disabilities, Aging and Independent Living.

1. The agency shall file for an appeal within 10 working days of a notice of suspension or decertification.

2. The Commissioner shall hear the appeal within 45 days of notice from the agency.

3. The Commissioner shall issue her or his decision in writing within 30 days of the hearing.

4. The agency's certification shall remain in place during the appeal process.

5. These deadlines may be increased if agreed to by both DAIL and the case management agency.

APPENDIX A

State and Federal Statutory Authority

I. **State Statute**: The Department of Disabilities, Aging and Independent Living has statutory authority to manage programs and protect the interests of older Vermonters and Vermonters with disabilities within Title 3, Chapter 53, Subchapter 004, Section 3885a of Vermont State Statutes.

The Commissioner has the authority to determine the policies and to exercise the powers and perform the duties required for the effective administration of the Department within Title 3, Chapter 53, Subchapter 003, Section 3052 of Vermont State Statues.

II. **Choices for Care**: Choices for Care is managed under Vermont's Global Commitment to Health 1115 Waiver. The Centers for Medicare and Medicaid Services (CMS) sets parameters for operations and quality management in the Code of Federal Regulations (State Assurances), Vermont's Special Terms and Conditions and Comprehensive Quality Strategy.

III. **Home and Community-Based Services (HCBS) Medicaid Regulations** – New HCBS Federal regulations (2014) set forth new requirements for HCBS settings standards and person-centered planning for people receiving services in home-based settings. The regulations are intended to enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

IV. **Older Americans Act**: The Older Americans Act (OAA) requires the State to be responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all state activities under the Act. Vermont is also responsible for setting specific objectives for each area for all services under the Act. 42 U.S.C.§3025 (a)(1)(c).

Vermont uses Title III-E funds to support case management activities. Vermont is required to establish standards and mechanisms designed to assure the quality of services, and to establish quality standards and mechanisms and accountability. 42 U.S.C.§3030s-1(e)(l).

OAA regulations require Vermont to develop policies governing all aspects of programs operated under Title III and to be responsible for the enforcement for these policies. (45C.F.R.§§1321.11 and 1321.17).

V. **Olmstead Decision**: On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate;

(2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Kennedy, Alice

From: Senghas, Stuart
Sent: Thursday, July 27, 2017 11:57 AM
To: Tierney-Ward, Megan
Subject: FW: For Review
Attachments: GMADS 2017 Cert Letter.doc

Megan,

Feel free to write colorized comments/feedback on letter and return.

Thanks!

Stuart

VERMONT

State of Vermont
Department of Disabilities, Aging and Independent Living
Adult Services Division
HC 2 South, 280 State Drive
Waterbury, VT 05671-2020
Phone: 802-241-0294
Fax: 802-241-0385
www.dail.vermont.gov

Agency of Human Services

July 20, 2017

Green Mountain Adult Day Services
148 Prouty Drive
Newport, VT 05855

Dear Linda,

This letter is to inform you that I have completed the 2017 Certification Review process for Green Mountain Adult Day Services (GMADS) of Orleans County located in Newport, Vermont. The review was conducted in July of 2017.

First and foremost, I want to thank you Linda for your support and the support of all your staff(s) during the review process.

During this process, I reviewed the outcome areas outlined in the Adult Day Review grid which highlights requirements from the Vermont Adult Day Standards.

This review found many areas of good service at GMADS in areas of person-centered support including, but not limited to, the respect and inclusion of participants input into the dynamics of initial service delivery and planning; an activity coordinator (Kesha) with extensive knowledge of this population and experience in providing quality activities; and a Director (Linda) with great rapport with participants and their families and extensive knowledge about the full range of services available to individuals in their region. Participant and caregiver feedback to this reviewer regarding GMADS services were generally positive and included high praise for you and your staff.

Attached to this letter is the Adult Day Review Grid completed during the review. The grid includes the adult day standards both met and not met. Below are areas of concern discovered during the review.

1. Staff Training: As stated in section **VI.E &** of the Standards (Grid): *Documentation of orientation and ongoing staff training is on file at the adult day center. Training for direct service staff shall be at least 12 hours per year.*

While there was documentation located (although poorly documented, organized and filed) compliance with required training hours was not met. It appears that the Director Linda Thayer only had 1.5 hours in 2016 and 6.0 hours in 2015.

2. Quality and Stakeholder Feedback: As stated in section **IV.E** of the Standards (Grid): *The QA/I process shall include at least an annual process whereby important stakeholders can provide formal feedback to the center. These stakeholders shall include participants, caregivers and community partners and anyone else the center deems appropriate. The results of the records shall be public.*

VERMONT

This reviewer found that there is no annual evaluation process in place where important stakeholders, including community partners, participants, caregivers and their families are requested to provide formal feedback of the GMADS program focusing on services offered and rendered. Of the feedback received specifically from participants of GMADS, the results of these were not made public. On pages 9, 10, and 45 of GMADS Policies and Procedures it discusses this process including an annual survey to be sent out. The Quality Assurance practices of GMADS as outlined in GMADS own manual, based on State Standards, are not being met. This includes a Quality process that includes a regular review of the programs alignment with the applicable federal HCBS rules regarding settings and person-centered planning (Sect. IV.C+D)

3. HCBS rules and compliance: Related to the GMADS alignment with the applicable federal Home and Community-Based Services (HCBS) rules regarding settings, there is a significant issue. The HCBS standards require that Adult Day Services be located in a home and community-based setting. The statute specifies that home and community-based settings do not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities.

NOTE: Per CMS Regulations 42 CFR Section 441:

(2) Home and community-based settings do not include the following:
(i) A nursing facility.
(ii) An institution for mental diseases.
(iii) An intermediate care facility for individuals with intellectual disabilities.
(iv) A hospital.
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

The concerns/items identified above need to be responded to in a Plan of Action which needs to be submitted to my attention within 15 days of receiving this report. Please refer to the Adult Day Certification Procedures for details. Full receipt of the adult day certification will be contingent upon our receipt of the Plan of Action plan and its' initiation.

Should you have any questions regarding the items addressed in this report or need assistance, please feel free to contact me. I can be reached at 802-585-5730 or electronically at stuart.senghas@vermont.gov.

I would like to acknowledge the high level of dedication of your GMADS staff in meeting the complex needs of the individuals you serve.

I enjoyed meeting the individual participants and again want to highlight the staff's dedication to the important work you all do.

I want to thank you again for your support and the support of all your staff(s) during the review process.

Respectfully,

Stuart Senghas, MSW
Quality and Program Participant Specialist
Cell: 802-585-5730 (w: 802-241-0307)

Kennedy, Alice

From: Courcelle, Andre
Sent: Thursday, November 02, 2017 9:52 AM
To: Tierney-Ward, Megan
Subject: FW: HCBS questions
Attachments: VT Milestone Template July 24 2017.docx

fyi

Andre' R Courcelle
Quality & Provider Relations Program Director
Adult Services Division
Department of Disabilities, Aging and Independent Living
280 State Drive HC-2 South
Waterbury, VT 05671-2070
Office: 802 786-2516
Fax: 802 786-5055
andre.courcelle@vermont.gov

From: Skaflestad, Shawn
Sent: Thursday, October 26, 2017 2:43 PM
To: Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: RE: HCBS questions

Hi Andre,

I am working on the separate survey for the case management agencies as well updated survey response rates for C4C and TBI. In the meantime – I have attached the milestone document to this email. As you can see – corrective actions identified in the systemic assessment work plans need to be completed by **3/17/2018** – while the provider assessments are due by **9/17/2018**.

Let me know if you have any additional questions.

Shawn

From: Courcelle, Andre
Sent: Wednesday, October 25, 2017 4:19 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Subject: HCBS questions

Hi Shawn,
I have few questions about the CQS/STP and the timeline for our milestones. I need your help with the following:

- Can you send me the completion list for the Provider Self-Assessment?
- We had discussed the possibility of an abbreviated assessment for the case management agencies which would consist of the provider information page and section 7 of the provider assessment. Has one been created?
- Is there a final version of the validation survey for program participants?
- Is the 15% sample overall program or by agency?

- Did DS complete the validation survey?
- Can you send me the updated milestone table that we worked on at the meeting in June?
- How was Cathy Hamilton contracted/paid for her services?

It would be helpful for me if we could connect by phone to discuss this at your earliest convenience. I'll be in Waterbury tomorrow, please let me know a day and time that works best for you.
Thanks for your help!

Andre' R Courcelle

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andre.courcelle@vermont.gov

VERMONT MILESTONE TEMPLATE: DRAFT July 20, 2017

SECTION	TOPIC	MILESTONE	SUB-MILESTONE	DUE DATE
I	**Systemic Assessment and Remediation (2)**	Completion of systemic assessment		Done
		Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.		
			Implementation of new rules and regulations: 50% complete	
			Implementation of new rules and regulations: 100% complete	**3/17/2018**
II	**Site-specific Assessments (e.g., HCBS Survey) (3)**	Completion of site-specific assessment		**9/17/2018**
		Incorporate results of settings analysis into final version of the STP and release for **public comment**		**11/17/2018**
		Submit final STP to CMS		**1/17/2019**
III	**Site-specific Remediation (3)**	Identify remedial action steps (i.e., corrective action plan) for **residential** settings based on site specific settings assessment and validation activity. Identify plan to validate		**11/17/2018**

HCBS CQS July 2018 000661

		results/outcomes of site specific settings assessment.		
		Can start as soon as 3/17/2019	Completion of residential provider remediation: 25%	**7/17/2021**
			Completion of residential provider remediation: 50%	**10/17/2021**
			Completion of residential provider remediation: 75%	**1/17/2022**
			Completion of residential provider remediation: 100%	**March 17, 2022**
		Identify remedial action steps (i. e, corrective action plan) for **non-residential** settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment.		
			Completion of non-residential provider remediation: 25%	

			Completion of non-residential provider remediation: 50%	
			Completion of non-residential provider remediation: 75%	
			Completion of non-residential provider remediation: 100%	
		Identification of settings that will not remain in the HCBS System	*Support*	**1/17/2019**
IV	**Heightened Scrutiny (4)**	Identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider		
		Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		
		Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and **release for public comment**		
		Submit STP with Heightened Scrutiny information to CMS for review		**1/1/2019**
		CMS Approval		*3/17/2019*

HCBS CQS July 2018 000663

V	**Relocation (2)**	**Complete** notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required.		**3/17/2021**
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 25%	
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 50%	
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 75%	
			Complete notification that setting is not in compliance with	

			HCBS settings requirements and that relocation is required: 100%	
		Complete beneficiary relocation across all providers.		**3/17/2022**
			Complete beneficiary relocation across all providers: 25%	
			Complete beneficiary relocation across all providers: 50%	
			Complete beneficiary relocation across all providers: 75%	
			Complete beneficiary relocation across all providers: 100%	**3/17/2022**

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Monday, July 02, 2018 12:32 PM
To: Courcelle, Andre; Tierney-Ward, Megan; Harrigan, Emma; Omland, Laurel; Clark, Bill
Cc: McFadden, Clare
Subject: FW: NEW CMS INFORMATION!!
Attachments: Health and Welfare CIB 6-28-2018.pdf; group-homes-joint-report.pdf; evv-good-faith-effort.pdf

Hi All – just in case you did not receive this from Clare – below are 2 HCBS related webinars. While both are related to our work – the latter (i.e., The Process for Final STP Approval) is directly related to our recent milestone discussion.

Best,

Shawn

From: McFadden, Clare
Sent: Monday, July 02, 2018 10:44 AM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>
Subject: FW: NEW CMS INFORMATION!!

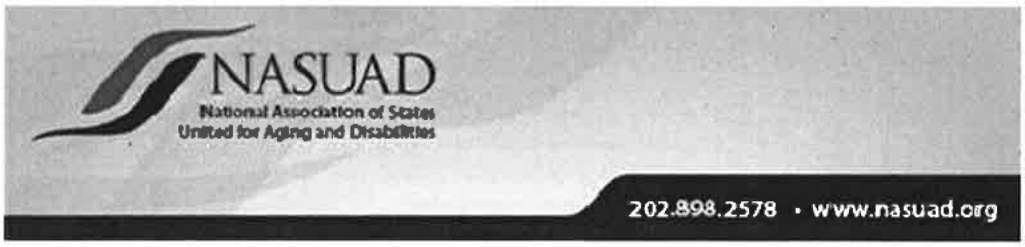
Hi Shawn- You may have received this already, but just in case, see the two webinars below related to HCBS rules. I will get someone from DDSD to attend, but others may want to as well.

From: George, Camille
Sent: Friday, June 29, 2018 10:29 AM
To: McFadden, Clare <Clare.McFadden@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>; Hill, Bard <Bard.Hill@vermont.gov>; Euber, Jim <Jim.Euber@vermont.gov>; Kelly, Bill <Bill.Kelly@vermont.gov>; Schurr, Stuart <Stuart.Schurr@vermont.gov>
Subject: Fwd: NEW CMS INFORMATION!!

Hi - some important info on a few topics, including a webinar on conflict free CM. Given our current status, I wonder if staff from ASD and DDSD should participate?

Get Outlook for iOS

From: Camille Dobson <cdobson@nasuad.org>
Sent: Thursday, June 28, 2018 11:57 AM
To: @NASUA
Subject: NEW CMS INFORMATION!!



****All recipients are Bcc'd****

Good Morning NASUAD Members:

We wanted to make sure you were aware of **two critical pieces of information that CMS released this morning on Medicaid.gov**.

1. An informational bulletin addressing the findings of the OIG/OCR/ACL Joint Report on state oversight of group homes that was issued in January. In the CIB, CMS urges states to review the recommendations included in the report and incorporate them into their critical incident management and quality assurance processes. We've attached both the CIB and the Joint Report for ease of reference.

2. Instructions and the necessary content that a state should include in its application for the 'good-faith' exemption for a 1-year delay in the EVV compliance deadline for personal care services that goes into effect on January 1, 2019. Only one request may be filed by a state between July 1 – November 30, 2018. We have attached the instructions here as well.

Additionally, CMS will be holding **two webinars (July 11 and July 18th)** on HCBS issues. We encourage you to register early and attend!

1. **Conflict of Interest Part II and Medicaid HCBS Case Management: July 11, 2018: 1:30pm – 3pm EST**
   The objective of this training is to build on the COI Part I training with a review of what constitutes conflict of interest (COI), including the HCBS rules regarding COI, and an overview on strategies for assessing your case management system, using data to inform stakeholders and decision-making, and tips for developing and implementing a corrective action plan (CAP). New Editions Consulting, Inc. is currently the training lead through the Home and Community Based Services Technical Assistance Contract overseen by the Division of Long Term Services & Supports (DLTSS). New Editions Consulting, Inc. will present the training and Ralph Lollar, DLTSS Division Director, and the DLTSS Team will support the training and lead the Q&A Session.
   To register for the webinar, click on this link:https://neweditions.adobeconnect.com/ealehps71yag/event/registration.html
2. **The Process for Final STP Approval: July 18, 2018: 2:00pm – 3:30pm EST**
   The objective of this training is to clarify CMS' expectations in order to grant final approval; describe requirements for site-specific assessment, validation, outcomes and remediation strategies; discuss the process for heightened scrutiny and consider processes for monitoring and quality assurance to ensure ongoing compliance. New Editions is currently the training lead through the HCB Settings Contract overseen by the Division of Long Term Services & Supports (DLTSS). New Editions will present the training and Ralph Lollar, DLTSS Division Director, and the DLTSS Team will support the training and lead the Q&A Session.
   To register for the webinar, click on this link: https://neweditions.adobeconnect.com/eow4ijn7h97n/event/registration.html

As always, please feel free to reach out to me or Damon if you have any questions or concerns.

Camille

Camille I. Dobson, MPA | Deputy Executive Director | NASUAD
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O: 202/499-5947 | M: 202/304-0336 |cdobson@nasuad.org

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Disabled and Elderly Health Programs Group

CMCS Informational Bulletin

DATE: June 28, 2018

FROM: Timothy B. Hill, Acting Director, Center for Medicaid and CHIP Services

SUBJECT: Health and Welfare of Home and Community Based Services (HCBS) Waiver Recipients

Introduction

The Center for Medicaid and CHIP Services (CMCS) is releasing this Informational Bulletin to address the issues outlined in the January 17, 2018 report titled "Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight"[1] ("the Joint Report") developed by three agencies of the Department of Health and Human Services: Administration for Community Living (ACL), Office for Civil Rights (OCR), and Office of Inspector General (OIG). CMS takes the health and welfare of individuals receiving Medicaid-funded Home and Community-Based Services (HCBS) very seriously, and we are providing the following CMS perspective on the issues raised in the Joint Report for state and stakeholder awareness.

This Bulletin addresses one of the three suggestions the Joint Report made to CMS: *encourage states to implement compliance oversight programs for group homes, such as the Model Practices, and regularly report to CMS.* Information contained here is consistent with the March 12, 2014 Informational Bulletin titled, "Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers[2]" and will not supplant and/or rescind that document. This release will be the first in a series on this topic of health and welfare. CMS intends to issue future guidance highlighting promising practices in effectuating the suggestions contained in the Joint Report, along with proposed performance metrics for evaluating the health and welfare of individuals receiving HCBS waiver services.

The Joint Report compiled individual audits across four states conducted by OIG to determine how states were ensuring the health and welfare of individuals with developmental disabilities

[1] https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf
[2] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf

residing in group homes[3]. In addition, proposed Model Practices for components of a robust oversight framework were identified in the Joint Report, including State Incident Management and Investigation, Incident Management Audits, State Mortality Reviews, and State Quality Assurance. Each of these is addressed below.

At the outset, CMS acknowledges that ensuring high quality HCBS to Medicaid beneficiaries is a shared goal among our state partners, provider communities, beneficiaries and their families and caregivers, and other stakeholders. Medicaid-funded HCBS play a critical role in facilitating beneficiary independence and community participation. The information contained here is meant to reaffirm CMS' commitment to provide necessary technical assistance to states in the development, implementation, and improvement of a quality oversight program. We encourage states to review this information as they look to strengthen their quality assurance system.

Incident Management and Investigation

A strong system of quality oversight utilizes a framework that defines and captures information on potential instances of abuse, neglect, or exploitation and emphasizes the importance of awareness and identification of critical incidents. There is no standard federally defined term for "critical incident" that outlines the scope of reportable incidents, leading to variation across states in the Medicaid program, and sometimes even across programs within the same state. Based on information contained in the Joint Report, along with the Agency's review of states' submitted HCBS waiver applications, CMS strongly encourages states to define critical incidents to, at a minimum, include unexpected deaths and broadly defined allegations of physical, psychological, emotional, verbal and sexual abuse, neglect, and exploitation. See pages A-iv and A-v of the Joint Report for a more comprehensive list of suggested reportable incidents. Awareness of critical incidents is the first step states require to determine whether an investigation or potential changes to the provision of services is necessary.

CMS supports the information contained in Appendix A of the Joint Report, titled "Model Practices for State Incident Management and Investigation" and finds it consistent with the expectations in the March 12, 2014 Informational Bulletin. Ensuring that the right information is generated at the provider/individual level and communicated to the state provides the basis for state-conducted review of data for timely trend analysis, investigations of specific incidents consistent with waiver materials and state policies, procedures and requirements, as well as implementation of any resulting corrective actions. The identification of emerging trends of concern is an important analysis for states to perform to determine whether systemic controls are in place or need improvement to prevent future incidents of abuse, neglect, and exploitation.

Reporting critical incidents plays an important role in a quality oversight program, and we believe that it is necessary to ensure that an approach to incident management is not perceived as punitive, but instead as an opportunity to help make quality oversight systems stronger. There is

[3] While there is no standard definition of a "group home," they tend to be congregate residential settings of various sizes in which individuals with a unifying characteristic or diagnosis – such as a developmental disability, mental illness, etc. - receive services.

a balance that CMS and the states must strike to ensure that we are encouraging, not inadvertently discouraging, providers and other stakeholders to report and resolve critical incidents and to be active participants in ongoing quality improvement efforts.

Incident Management Audits

States are encouraged to conduct audits of their incident management systems to ensure that information on all occurrences meeting the state's definition of a critical incident are reported appropriately and lead to investigations to determine the need for any corrective actions. This is consistent with the instructions for administrative oversight in the section 1915(c) Instructions, Technical Guide and Review Criteria. The information contained in Appendix B of the Joint Report, titled "Model Practices for Incident Management Audits," provides a good resource for how these audits could be conducted. While the OIG audits focused on incidents that led to hospital emergency department visits, CMS recognizes that not all emergency department utilization is due to abuse, neglect, or exploitation; likewise, not all incidents of abuse, neglect, or exploitation result in emergency department visits. States should implement an auditing protocol that captures all incidents that are relevant to the state's definitions of critical incidents, and reflects all locations in which those incidents could occur.

In response to the Joint Report's suggestions to review Medicaid claims data as part of incident management audits, CMS acknowledges that potential time lags between service provision and claims submission may make this type of review most appropriate on a retrospective basis to identify where incidents have been reported and/or not reported consistent with the emergency department visits audit, trends, and potential system improvement strategies.

Mortality Reviews

CMS agrees with the role that reviews of beneficiary deaths can have in a state's overall quality oversight system. CMS also agrees with the information contained in Appendix C of the Joint Report, titled "Model Practices for State Mortality Reviews". The distinction on page C-ii of the Joint Report is important: while states should require a preliminary review of all beneficiary deaths, investigations should focus on deaths that are determined to be "unusual, suspicious, sudden and unexpected, or potentially preventable, including all deaths alleged or suspected to be associated with neglect, abuse, or criminal acts." CMS recognizes that state Medicaid agencies and state operating agencies cannot mandate that autopsies be performed. States are encouraged to establish relationships with relevant agencies performing autopsies to maximize the likelihood of their performance upon state request. CMS notes the significance of mortality reviews in identifying trends in critical incidents and implementing systemic interventions that help protect against such critical incidents.

Quality Assurance

Appendix D of the Joint Report, titled "Model Practices for State Quality Assurance," brings information discussed earlier in the Report together into a comprehensive quality oversight

strategy. CMS, working with State Associations and representative states, agreed that this was a critical need in the state's Quality System for Health and Welfare issues and communicated that in the 2014 Informational Bulletin. CMS supports the infrastructure described in Appendix D of the Joint Report, including the focus on ensuring the provision of person-centered planning and services, and the inclusion of beneficiaries and other stakeholders in the development and implementation of a HCBS quality oversight program.

Ensuring the transparency of information associated with HCBS quality oversight is a critical step in fully utilizing the perspectives of such a wide array of stakeholders. States are encouraged to establish regular and clear communications with stakeholders, including individuals receiving or on a waiting list for HCBS. All reports generated as part of a state's HCBS quality assurance program should be published online and made available (in plain English and other relevant languages) to stakeholders. Finally, states are encouraged to identify ways to close feedback loops with individuals who are experiencing difficulties in receiving HCBS.

Next Steps

CMS encourages states, providers, and other stakeholders to become familiar with the Model Practices contained in the Joint Report. They represent sound recommendations in the implementation of good quality management programs and are consistent with the March 12, 2014 Informational Bulletin. In upcoming guidance, CMS intends to highlight examples of how these recommendations are being successfully utilized in the delivery of HCBS. CMS remains available to provide technical assistance on quality oversight to states under the various HCBS authorities.

CMS notes the potential availability of enhanced federal matching funds for state activities to implement the Model Practices described in the Joint Report. Enhanced federal administrative match of 75% may be available for these activities if they are part of a medical and utilization review performed by certain utilization and quality control peer review organizations under subsections (b)(6)(i) and (b)(10) of 42 CFR 433.15. CMS encourages states to enlist the assistance of qualified entities in this important work. States may contact their CMS Regional Office to discuss the possibility of enhanced administrative matching and the development of an administrative claiming plan for CMS review and approval. Likewise, states may also contact their Regional Office to determine the availability of 90% federal match for expenditures related to development of an automated data processing (ADP) system through the advanced planning document (APD) process under 42 CFR 433.112(a).

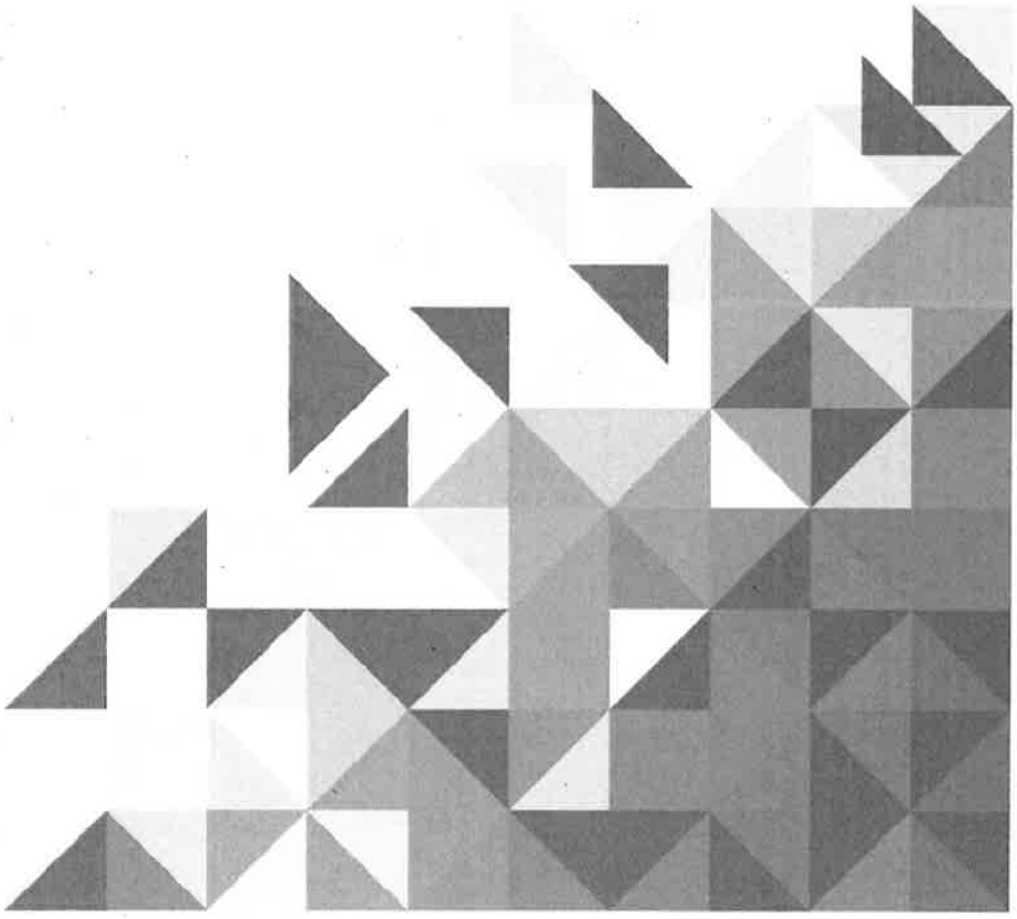
CMS looks forward to working with states in continued efforts to assist Medicaid beneficiaries in maintaining community integration and receiving quality services.

Joint Report

U.S. Department of Health and Human Services
Office of Inspector General,
Administration for Community Living, and
Office for Civil Rights

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

January 2018



The Department of Health and Human Services (HHS), Office of Inspector General (OIG), provides independent and objective oversight that promotes economy, efficiency, and effectiveness in HHS programs and operations. OIG's program integrity and oversight activities are shaped by legislative and budgetary requirements and adhere to professional standards established by the Government Accountability Office (GAO), the Department of Justice (DOJ), and the Inspectors General community. OIG carries out its mission to protect the integrity of HHS programs and the health and welfare of the people served by those programs through a nation-wide network of audits, investigations, and evaluations.

The Administration for Community Living (ACL) serves as the Federal agency responsible for increasing access to community supports while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. By funding services and supports provided by networks of community-based organizations and with investments in research and innovation, ACL helps make this principle a reality for millions of Americans.

The HHS Office for Civil Rights (OCR) is the Department's civil rights, conscience and religious freedom, and health privacy rights law enforcement agency. OCR's disability nondiscrimination enforcement authorities include Section 504 of the Rehabilitation Act, Title II of the Americans with Disabilities Act, and Section 1557 of the Affordable Care Act.

Joint Report

ACL Administration for Community Living

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

Group Home Beneficiaries Are at Risk of Serious Harm

- OIG found that health and safety policies and procedures were not being followed. Failure to comply with these policies and procedures left group home beneficiaries at risk of serious harm.
- These are not isolated incidents but a systemic problem – 49 States had media reports of health and safety problems in group homes.

A Roadmap for States – Compliance Oversight Model Practices

A toolbox for better health and safety outcomes in group homes

Model Practices for State Incident Management and Investigation

- Reporting and notification
- Incident review
- Investigation
- Corrective action and implementation
- Trend analysis

Model Practices for State Incident Management Audits

- Assess incident reporting
- Assess response and review of incidents
- Assess investigations
- Assess corrective actions
- Assess identification and response to incident trends

Model Practices for State Mortality Reviews

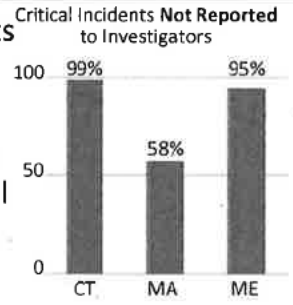
- Identify cause and circumstances of beneficiary death
- Where warranted, take corrective action
- Identify mortality trends
- Systemic responses and evaluation of their efficacy
- Reporting

Model Practices for State Quality Assurance

- Oversight of service planning and delivery
- Periodic assessment of performance
- Review network capacity and accessibility
- Compliance monitoring of requirements and outcomes

OIG Group Home Health and Safety Work

- **Objective:** To determine if group homes complied with Federal and State requirements for reporting, recording, and detecting critical incidents in group homes
- **Where we did the work:** Connecticut, Massachusetts, and Maine
- **Finding:** OIG found serious lapses in basic health and safety practices in group homes.
- **Recommendations:** Connecticut, Massachusetts, and Maine should provide additional training, update policies and procedures, and provide access to Medicaid claims data.
- **Referrals**: OIG made multiple referrals to local law enforcement to address specific incidents of harm.



Examples

Connecticut did not report to investigators three separate critical incidents. A resident suffered from repeated head injuries that required treatment at a local hospital's emergency room. An immediate protective service order was issued for the beneficiary based on information OIG provided.

Massachusetts did not report to investigators two separate critical incidents. A resident suffered head lacerations while being restrained by the group home's aides. The resident required treatment at a local hospital's emergency room. Investigations were opened for both incidents based on information OIG provided.

OIG Reports on Group Home Health and Safety

- *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (May 2016 – A-01-14-00002)*
- *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (July 2016 – A-01-14-00008)*
- *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (August 2017 – A-01-16-00001)*

Government Partnership – OIG, ACL, and OCR

- **Depth of expertise** and **multiple perspectives**
- Developing a set of **Model Practices that provide States with a roadmap** for how to implement better health and safety practices, many of which are already required
- **Coordination with: DOJ, CMS, State stakeholders**

Joint Report Suggestions to CMS:

CMS Guidance	CMS "SWAT" Team	CMS Take Action
Encourage States to implement compliance oversight programs for group homes, such as the Model Practices, and regularly report to CMS	Form a "SWAT" team to address systemic problems in State implementation and compliance with health and safety oversight	Take immediate action in response to serious health and safety findings in group homes, using authorities under 42 CFR § 441.304(g)

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I. EXECUTIVE SUMMARY

This joint report is issued by the U.S. Department of Health and Human Services, Office of Inspector General (OIG); Administration for Community Living (ACL); and Office for Civil Rights (OCR) to help improve the health, safety, and respect for the civil rights of individuals living in group homes. The joint report provides suggested model practices to the Centers for Medicare & Medicaid Services (CMS) and States for comprehensive compliance oversight of group homes to help ensure better health and safety outcomes. In addition, the Joint Report provides suggestions for how CMS can assist States when serious health and safety issues arise that require immediate attention.

In recent decades, the United States has seen a shift from institutional care settings to more community-based services and supports. This change is attributable to multiple factors, including a growing desire of individuals, including individuals with disabilities, to live and participate in typical communities; the increased flexibility and use of Medicaid funding for community-based, long-term services and supports; and the implementation of the Supreme Court's *Olmstead* decision.[1] In addition, community-based settings, such as group homes, provide many individuals with greater independence, the choice to live in the community, and access to other opportunities.

Access to services that support community living is a key part of this transformation. Group homes and other residential settings that meet the requirements for home and community-based service provision as defined by the U.S. Department of Health and Human Services (HHS), CMS, are part of the spectrum of integrated options. However, individuals with developmental disabilities are at higher risk of abuse and neglect, particularly where they live (irrespective of residential setting type), and may have little or no access to police, support services, or external advocates.[2]

82 of the 1,361 deaths of individuals with developmental disabilities in Connecticut involved suspected abuse or neglect.

– CT OPA Report (2012)

In response to a congressional request concerning the number of deaths and cases of abuse of individuals with developmental disabilities residing in group homes, OIG performed reviews in four States. The congressional request arose in part because of a 2012

[1] In *Olmstead* v. *L.C.*, 527 U.S. 581 (1999), the U.S. Supreme Court established that unjustified isolation is a form of discrimination under the Americans with Disabilities Act.

[2] Christy J. Carroll, Efthalia Esser, and Tracey L. Abbott. *State of the States on Abuse and Neglect of Individuals with Developmental Disabilities*. North Dakota Center for Persons with Disabilities, Minot State University, 2010. Available at http://www.ndcpd.org/assets/abuse--neglect-state-of-the-state-paper.pdf. Accessed on October 18, 2017. See also OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements* (A-01-17-00504). Available at https://oig.hhs.gov/newsroom/media-materials/2017/2017-snf.asp. Accessed on November 8, 2017. OIG identified 134 Medicare beneficiaries whose injuries may have been the result of potential abuse or neglect that occurred from January 1, 2015, through December 31, 2016. OIG also found that a significant percentage of these incidents may not have been reported to law enforcement.

report issued by the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA) that found that 82 of the 1,361 deaths state-wide of individuals with developmental disabilities from January 2004 through December 2010 involved suspected abuse or neglect. OPA investigated 81 of those deaths. The deaths involved individuals with injuries such as broken bones; safety issues such as choking incidents and burns associated with scalding; car accidents involving unlicensed drivers; and inadequate medical services at private and public group homes, State training schools, regional centers, skilled nursing facilities, and hospitals. Investigators cited abuse, neglect, and medical errors as contributing factors in these deaths.

OIG's objective in its reviews was to identify instances in which the State agencies that administer the State Medicaid program did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who reside in group homes.

An Example of a Group Home's Unreported Critical Incident

A group home did not report a critical incident involving a resident with developmental disabilities. This resident suffered a second-degree burn on his right shoulder that required treatment at a local hospital's emergency room. The group home's aide, while assisting the resident in taking a shower, noticed the injury. The resident's medical records noted the aide stated that the cause of the injury was unknown and the resident could not describe how he received the injury. Because the injury met the definition of a "critical incident," the group home should have reported it.

In OIG's audits of Connecticut, Massachusetts, and Maine, the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. These audits found that these State agencies:

- failed to ensure that group homes reported all critical incidents,
- failed to ensure that all critical incidents reported by group homes were properly recorded,
- failed to ensure that group homes always reported incidents at the correct severity level,
- failed to ensure that all data on critical incidents were collected and reviewed, and
- failed to ensure that reasonable suspicions of abuse or neglect were properly reported.

As a result of these and similar findings, OIG began meeting regularly with colleagues in the Administration for Community Living and the HHS Office for Civil Rights. The goal was to combine these Federal stakeholders' knowledge and resources to develop comprehensive suggestions for CMS and States that would improve the health and safety of group home beneficiaries while helping maintain their independence.[3] In addition, the Department of

[3] See Appendix E for related HHS reports and activities.

Justice (DOJ), Civil Rights Division, provided technical assistance based on its experience with incident management and quality assurance processes that help qualified individuals with disabilities live successfully in community-based settings. We also sought input from CMS and State stakeholders when developing these comprehensive compliance oversight suggested practices.

OIG, ACL, and OCR recognize there are limitations on the ability of a broad set of compliance oversight practices to fully encompass the varying and diverse legal, cultural, and regional differences of every State in the country. Accordingly, we seek to assist CMS in empowering State government partners to bring about the highest level of health and safety possible for group home beneficiaries. Our suggestions for CMS are focused on State compliance oversight practices, as well as, actions CMS can take to support States and beneficiaries when systemic and serious health and safety issues arise.

Our suggestions for ensuring group-home beneficiary health and safety involve four key compliance oversight components:

1. reliable incident management and investigation processes;
2. audit protocols that ensure compliance with reporting, review, and response requirements;
3. effective mortality reviews of unexpected deaths; and
4. quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community-based services.

Accordingly, we developed four sets of Model Practices that address each of these key components and align with the requirements currently contained in the CMS Home and Community-Based Services (HCBS) Waiver (see HCBS waiver, Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents[4]). The four Model Practices are:

Model Practices for State Incident Management and Investigation (Appendix A)

Model Practices for Incident Management Audits (Appendix B)

Model Practices for State Mortality Reviews (Appendix C)

Model Practices for State Quality Assurance (Appendix D)

[4] Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/hcbs-waivers-application.pdf. Accessed on November 8, 2017.

Collectively implementing these four suggested compliance oversight components should help substantially to ensure the protection of beneficiaries' health, safety, and civil rights; the accountability of provider and service agencies; and the delivery of public services compatible with funding expectations and commitments. These elements are explained more fully in the appendices. We believe that these Model Practices provide a roadmap for States that will help them to ensure the health and safety of group home beneficiaries. States may adopt these Model Practices in whole or in part, depending on the needs of their particular State and population. Although these Model Practices focus specifically on the group home setting, many elements may apply to other noninstitutional care settings as well.

II. BACKGROUND

HHS OIG performed reviews in four States in response to a congressional request concerning the number of deaths and cases of abuse of individuals with developmental disabilities residing in group homes. The congressional request arose in part because of a 2012 report issued by the Connecticut OPA, which found that 82 of the 1,361 deaths state-wide of people with developmental disabilities, from January 2004 through December 2010, involved suspected abuse or neglect. OPA investigated 81 of those deaths. The deaths involved individuals with injuries such as broken bones; safety issues such as choking incidents and burns associated with scalding; car accidents involving unlicensed drivers; and inadequate medical services at private and public group homes, State training schools, regional centers, skilled nursing facilities, and hospitals. Investigators cited abuse, neglect, and medical errors as contributing factors in these deaths.

OIG's objective was to identify instances in which State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes.

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Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has

considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Waiver (HCBS waiver) program (the Act § 1915(c)). The program permits a State to furnish home and community-based services that assist Medicaid beneficiaries and make it possible for them to live in the community and avoid institutionalization. There are a number of community-based residential options through which individuals with developmental disabilities can receive Medicaid-funded HCBS, depending on what is offered in a particular State's waiver.[5] Waiver services complement or supplement the services that are available to participants through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of specific populations targeted by the State under its HCBS waiver authority.

Medicaid permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries and make it possible for them to live in the community and avoid institutionalization.

State agencies may administer the HCBS waivers and implement portions of the waivers through interdepartmental service agreements with other units of State government. The HCBS waiver program supports individuals who require comprehensive support services. These individuals reside either in an out-of-home setting, such as a group home, with 24-hour support or in their family or own home with additional in-home support and supervision.

States must provide certain assurances to CMS to receive approval for HCBS waivers, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). A State must provide specific information regarding its plan or process related to beneficiary safeguards, which includes whether the State operates a critical event or incident reporting system (see HCBS waiver, Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents). In its waiver, a State agency generally reports that it has a critical event or incident reporting system that relies on the policies and procedures of the State Department of Developmental Services (DDS) (or a similar State agency).

[5] Medicaid beneficiaries eligible for waiver services can receive HCBS in group homes, host homes or adult foster care arrangements, supported living options in apartments or homes with roommates of their choosing, family homes, or privately owned individual homes owned or rented by the beneficiary. The audit conducted by OIG was confined solely to a review of reporting and monitoring actions involving individuals with developmental disabilities living in group homes.

Critical Incident Reporting for Group Homes

The classification of critical incidents in HCBS waivers varies across States and the specific population served by the waiver. The HCBS waiver may classify critical incidents as requiring either a minor or major level of review. Critical incidents requiring a major level of review generally include deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing persons, and serious injuries. Critical incidents requiring a minor level of review generally include suspected verbal or emotional abuse, theft, and property damage. For critical incidents that involve suspected abuse or neglect, the HCBS waiver and State regulations also require mandated reporting.

Critical Incidents

- Deaths
- Physical/sexual assault
- Suicide attempts
- Unplanned hospitalizations
- Near drowning
- Missing persons
- Serious Injuries

How OIG Conducted Its Reviews

OIG reviewed Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes at selected State agencies. OIG conducted these reviews in Connecticut, Massachusetts, New York, and Maine using Medicaid claims data. OIG's audit period for this series of reviews was from 2012 to 2015. OIG's audit reports on these reviews made recommendations to the State agencies regarding improving policies and procedures.

OIG conducted these performance audits in accordance with generally accepted government auditing standards. Those standards require that audits be planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on audit objectives. OIG believes that the evidence obtained provides a reasonable basis for its findings and conclusions based on its audit objectives. OIG's work in this area is continuing in additional States and settings such as skilled nursing facilities. OIG will be issuing a report to CMS that consolidates findings from the individual States. The report will contain specific recommendations to CMS to help improve the program.

OIG's Findings

In OIG's audits of Connecticut, Massachusetts, and Maine, the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. Summaries of five of OIG's findings follow.

1. State Agencies Did Not Ensure That Group Homes Reported All Critical Incidents

Group homes in Connecticut and Massachusetts and community-based providers in Maine are required to report critical incidents to the State DDS (for Connecticut and Massachusetts) or to the State agency for Maine. OIG found that group homes and community-based providers did not report all critical incidents involving Medicaid beneficiaries with developmental disabilities. In Connecticut, of the 310 emergency room visits by 245 of these Medicaid beneficiaries, 176 visits met DDS's definition at the time of a critical incident because they included a severe injury. However, group homes did not report 24 (14 percent) of the critical incidents to DDS. In Massachusetts, group homes reported 499 (85 percent) of the 587 critical incidents treated in hospital emergency rooms. However, group homes did not report to DDS 88 (15 percent) of the critical incidents. In Maine, community-based providers reported 1,474 (66 percent) of the 2,243 critical incidents treated in hospital emergency rooms. However, community-based providers did not report to the State agency 769 (34 percent) of the critical incidents.

An Example of a Group Home's Unreported Critical Incident

A group home did not report to DDS a critical incident involving a resident with Down syndrome and dementia. The resident was encouraged to wear a helmet for protection during seizures and a gait belt when he transferred positions. The resident required one-on-one supervision while walking during a number of specified activities within the group home. The resident had an unwitnessed fall in the group home's kitchen, which was followed by a period of unconsciousness. Hospital emergency room staff evaluated the resident for a trauma to the right side of his head and face with computerized axial tomography. Because these injuries met the DDS definitions of a "critical incident" and a "severe injury," the group home should have reported the incident immediately.

An Example of a Group Home's Unreported Critical Incident

A group home did not report to DDS a critical incident involving a resident with developmental disabilities. This resident suffered a second-degree burn on his right shoulder that required treatment at a local hospital's emergency room. The injury was noticed by one of the group home's aides who was helping the resident take a shower. The aide stated that the cause of the injury was unknown and that the resident could not describe how he received the injury. Because the injury met the DDS definition of a "critical incident," the group home should have reported the incident.

An Example of a Critical Incident Not Reported by the Community-Based Provider

A community-based provider did not report to the State agency a critical incident involving a beneficiary with developmental disabilities. This beneficiary suffered a laceration of unknown origin to her left ear that required treatment at a local hospital's emergency room. The injury was a jagged laceration that required suturing to close the wound. The community-based provider's staff stated the cause of the injury was unknown and that the beneficiary could not

provide a history of the injury. Because the injury met the State agency's definition of a "critical incident," the community-based provider should have reported the incident.

2. State Agencies Did Not Ensure That All Critical Incidents Reported by Group Homes Were Properly Recorded

In Connecticut, OIG found that DDS did not record all critical incidents reported by group homes. Specifically, group homes reported 152 critical incidents to DDS, but DDS did not record 34 (22 percent) of these incidents into its incident reporting system. Because DDS did not record these incidents, the DDS Division of Investigations and OPA never received notice that these incidents occurred and, therefore, could not determine whether abuse or neglect contributed to these injuries. DDS did not enter all critical incidents into its incident reporting system because it did not always follow procedures. Furthermore, these unrecorded critical incidents were not detected because DDS did not have a way to coordinate with the State agency to detect unrecorded and unreported critical incidents.

An Example of a Critical Incident Not Recorded by DDS

A group home reported to DDS a critical incident involving a resident with developmental disabilities who used a wheelchair and had cerebral palsy and pulmonary disease. The group home's staff reported the resident was dropped while being transferred. This resident suffered a displaced fractured clavicle that required treatment at a local hospital's emergency room. Hospital staff used x-rays in their evaluation of him. Because the group home reported this incident to DDS, DDS should have entered the incident into its incident reporting system within 5 days. DDS, however, did not record the incident.

3. State Agencies Did Not Ensure That Group Homes Always Reported Incidents at the Correct Severity Level

In Connecticut, OIG found that group homes did not always correctly report to DDS emergency room visits related to severe injuries, which DDS would have treated as critical incidents. Instead, the group homes frequently reported to DDS emergency room visits as involving either minor or moderate injuries. Even though emergency room visits involving minor and moderate injuries are reportable, DDS did not treat them as critical incidents. DDS reviewed the 176 emergency room records supplied by OIG and determined that 86 (49 percent) emergency room visits originally classified by the group homes as involving either minor or moderate injuries actually involved severe injuries and would have therefore met Connecticut's definition of critical incidents. Accordingly, State agencies could not investigate these 86 critical incidents for potential abuse or neglect.

An Example of a Group Home Reporting the Incorrect Severity Level of an Injury

A group home reported injuries involving a resident with developmental disabilities, scoliosis, and spastic paralysis of all four limbs at an incorrect severity level. This resident suffered a lacerated upper lip, facial contusions, an acute cervical strain, and a fractured tooth; these injuries required treatment at a local hospital's emergency room. During the resident's

treatment, hospital staff evaluated him for additional spine and skull injuries using computerized axial tomography. The group home's staff reported that the resident was injured when he fell from a shower chair, but they also reported that they did not witness his fall. The group home reported these injuries to DDS, but it reported the severity level of the injuries as only "moderate" instead of "severe." As a result, this critical incident was not investigated by either DDS or OPA for potential abuse or neglect.

4. State Agencies Did Not Ensure That All Data on Critical Incidents Were Collected and Reviewed

In Connecticut and Massachusetts, OIG found that DDS did not review and analyze all data on critical incidents. In Connecticut, DDS reviewed medication errors quarterly, but it reviewed internal critical incident data only annually. DDS did not have a way to obtain all data regarding critical events and incidents from the State agency. Accordingly, DDS could not review relevant Medicaid claims data for injuries that required emergency room treatment or hospital admission—key elements in determining whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes. If DDS had access to relevant Medicaid claims data as contained in the Connecticut Medicaid Management Information System (MMIS), it could have performed a data match similar to the one OIG performed. Because it could not, DDS was unable to detect the 24 critical incidents that group homes did not report or the 34 critical incidents that group homes reported but DDS did not enter into its incident reporting system.

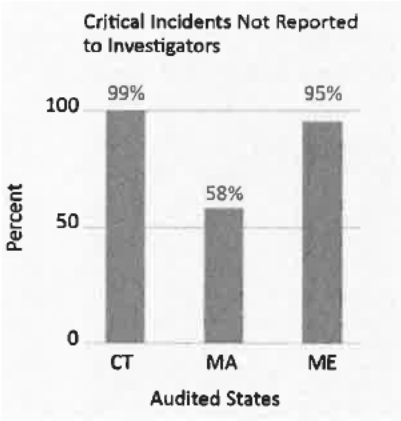
In Massachusetts, DDS reviewed and analyzed only the incidents that were reported by the group homes. DDS did not have a way to obtain and analyze all data regarding critical incidents from the State agency. Accordingly, DDS could not analyze relevant Medicaid claims data for injuries that required emergency room visits or hospital admissions—key elements in determining whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes. If DDS had access to the relevant Medicaid claims data as contained in the Massachusetts MMIS, it could have performed a data match similar to the one OIG performed. Because it could not, DDS was unable to detect the 88 critical incidents that group homes did not report.

5. State Agencies Did Not Ensure That Reasonable Suspicions of Abuse or Neglect Were Properly Reported

In Connecticut, Massachusetts, and Maine, OIG found that they did not always report reasonable suspicions of abuse or neglect.

Although Connecticut group homes reported 152 critical incidents to DDS during the period of our audit, DDS did not report 151 of the 152 to OPA as potential incidents of abuse or neglect involving Medicaid beneficiaries who had developmental disabilities. OIG reported to OPA the 176 critical incidents it identified during its audit (the 152 critical incidents that DDS did not

report and 24 critical incidents that group homes failed to report). OPA stated that DDS should have reported all 176 as incidents with a reasonable suspicion of abuse or neglect. OPA then opened 24 new investigations and updated 9 ongoing investigations—33 critical incidents involving potential abuse or neglect. *OPA also issued 8 immediate protective service orders involving 14 critical incidents to protect group home residents with developmental disabilities from potential harm.*



In Massachusetts, of the 587 critical incidents involving Medicaid beneficiaries with developmental disabilities that occurred during the period of our review, 73 (12 percent) were reported to the Disabled Persons Protection Commission (DPPC) as potential incidents of abuse or neglect. However, the remaining 514 (88 percent) were not reported to DPPC. OIG reported to DPPC the 514 unreported critical incidents it identified. DPPC officials stated that they believed that 102 of the unreported incidents (20 percent) should have been reported as incidents with reasonable suspicion of abuse or neglect. DPPC officials stated that 240 incidents (47 percent) did not have to be reported and that they did not have enough information to determine whether the remaining 172 incidents (33 percent) should have been reported. Therefore, OIG determined that staff of DDS and group homes did not report as required 58 percent of the 175 incidents (73 critical incidents reported to DPPC plus 102 additional critical incidents that should have been reported) that met the State's "reasonable cause to believe" threshold regarding whether a suspicion of abuse or neglect exists.

In Maine, the State agency must also immediately report the suspected abuse, neglect, or exploitation of an incapacitated or dependent adult to the appropriate district attorney's office. The State agency did not report all suspected incidents of abuse, neglect, or exploitation to the appropriate district attorney's office. During the audit period, the State agency received 15,939 critical incident reports for 15,897 individual critical incidents related to potential abuse or neglect involving 1,886 beneficiaries from community-based providers. There were no records demonstrating that the State agency reported 15,130 (95 percent) of the 15,897 critical incidents.[6]

An Example of DDS Not Reporting a Critical Incident That Had Reasonable Suspicion of Abuse or Neglect

Connecticut DDS did not report to OPA any of the three separate critical incidents that occurred in 2012 and 2013 involving a nonverbal group home resident with cerebral palsy and a history of self-injury. This resident suffered from repeated head injuries that required treatment at a local

[6] Maine State agency staff review critical incident reports submitted to the State agency and determine if the reports should be sent to an Adult Protective Services Unit supervisor for further assessment. A State agency supervisor reviews the reports and decides whether or not the State agency will accept the reports for investigation. The "Not Accepted for Investigation" category includes critical incidents for which the State agency (1) completed an assessment but did not accept for investigation and (2) did not complete an assessment for investigation. We did not determine how many critical incidents were not assessed for investigation.

hospital's emergency room. These injuries included contusions with bruising and swelling of the head and face. This resident was evaluated with x-rays and computerized axial tomography. Because these injuries met the DDS definition of a "critical incident" and there was reasonable evidence to suspect abuse or neglect, DDS should have reported the incidents immediately to OPA. *On the basis of the information OIG provided, OPA issued an immediate protective service order for this beneficiary.*

An Example of DDS Not Reporting a Critical Incident That Had Reasonable Suspicion of Abuse or Neglect

Staff of the Massachusetts DDS and the group home did not report to DPPC either of two separate critical incidents that occurred in December 2013 and April 2014 involving a resident with oppositional defiance disorder and seizures. This resident suffered head lacerations that required treatment at a local hospital's emergency room. The medical records noted that the resident was injured while being restrained by the group home's aides. The resident cut her head on a bed headboard during the first incident and on a chair during the second incident. In each case, the group home submitted an incident report to DDS, but neither DDS staff nor group home staff filed a report with DPPC. Because these injuries met the DDS definition of a "critical incident" and DPPC officials stated that there was reasonable evidence to suspect abuse or neglect, DDS should have reported the incidents immediately to DPPC. *On the basis of the information OIG provided, DPPC opened investigations of both incidents.*

The Formation of an Interagency Group To Examine Group Home Health and Safety

As a result of these and similar findings, OIG contacted stakeholders across Government that shared our interest and concerns in the area of group-home health and safety. OIG's Federal partners shared a concern about the systemic failures identified in critical incident reporting and monitoring of incident management within group homes. The group also realized that strong incident reporting and management systems constitute a critical element of enhanced quality assurance for community-based settings. OIG began meeting regularly with its colleagues in the Administration for Community Living and the HHS Office for Civil Rights. We hoped to combine our knowledge and resources to develop comprehensive suggestions for CMS and States that would improve the health and safety of group home beneficiaries across the country. In addition, we received technical assistance from DOJ, Civil Rights Division, and sought input from CMS and State stakeholders. While this approach is unusual, we believe the magnitude of the danger for beneficiaries has warranted this effort and the joint report that has come from it.

While this approach is unusual, we believe the magnitude of the danger for beneficiaries has warranted this effort and the joint report that has come from it.

This interagency group began meeting in August 2016 to discuss and examine how to ensure the systemic health and safety of group home beneficiaries. The group developed three suggestions for CMS. First, we developed a model for comprehensive compliance oversight through four Model Practices that address the key components of ensuring beneficiary health and safety and that align with the requirements currently contained in the 1915(c) HCBS waiver (Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents). The four Model Practices are:

Model Practices for State Incident Management and Investigation (Appendix A)

Model Practices for Incident Management Audits (Appendix B)

Model Practices for State Mortality Reviews (Appendix C)

Model Practices for State Quality Assurance (Appendix D)

We believe that these Model Practices provide a roadmap for States that will empower them to ensure the health and safety of group home beneficiaries. States may adopt these Model Practices in whole or in part depending on the needs of their particular State and population. Although these Model Practices are specifically focused on the group home setting, many elements may apply to other noninstitutional care settings as well.

Second and third, we developed suggestions for actions CMS can take to support States and beneficiaries when systemic and serious health and safety problems arise in group homes. Where there is evidence of a systemic failure to implement compliance oversight for group homes, CMS should form a "SWAT" team to assist the State in addressing the problem effectively. Where there are serious health and safety findings, CMS should take immediate action, using its authorities under 42 CFR § 441.304(g) for group homes, to ensure that beneficiaries are safe.

III. KEY COMPONENTS OF HEALTH AND SAFETY COMPLIANCE OVERSIGHT

Generally, assurance of program beneficiary health and safety involves four critical components:

1. reliable incident management and investigation processes;
2. audit protocols that ensure compliance with reporting, review, and response requirements;
3. effective mortality reviews of unexpected deaths; and
4. quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community-based services.

Collectively, these four compliance oversight components help ensure that beneficiary health, safety, and civil rights are adequately protected, that provider and service agencies operate under appropriate accountability mechanisms, and that public services are delivered consistent with funding expectations.

In turn, each of these four components of health and safety assurances must embody certain critical elements to be effective and reliable. These elements are delineated in the Model Practices presented in Appendices A through D. As noted, these practices align with existing requirements contained in the HCBS waiver (Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents).

1. Reliable Incident Management and Investigation Processes

Incident management involves providing immediate and effective responses to serious incidents to protect the involved beneficiary's safety and well-being and to mitigate reoccurrence. It also involves ensuring that the facts and circumstances of serious incidents are reviewed quickly and effectively and, as warranted, investigated. It includes ensuring that trends and patterns regarding serious incidents are identified and addressed through timely implementation of effective corrective actions (e.g., additional provider and staff training focused on both quality assurance and improvement, necessary changes and reforms to specific protocols in service delivery, and enhancements to standard operating policies). It involves ensuring that appropriate governmental entities and provider and support coordination agencies receive timely notification of serious incidents, and it includes public reporting regarding the overall safety and well-being of Medicaid beneficiaries.

2. Audit Protocols That Ensure Compliance With Reporting, Review, and Response Requirements

An effective audit system of public agency and provider incident management activities involves processes to assess for timely and appropriate incident reporting, investigation, and response and for implementation of timely and appropriate corrective actions to minimize reoccurrence. It also involves assessments to determine if public agencies and providers are undertaking systemic reviews to identify and appropriately address incident trends or patterns.

3. Effective Mortality Reviews of Unexpected Deaths

An effective mortality review protocol involves timely reporting of all beneficiary deaths, including identification of the cause of death and the circumstances contributing to or associated with the death. It includes, where warranted, identification and implementation of corrective actions likely to minimize the reoccurrence of the immediate factors contributing to the death. It also includes identification of mortality trends and patterns that warrant systemic responses to reduce avoidable risks of death and other adverse outcomes. It includes the timely implementation of systemic responses and ongoing evaluation of their efficacy. And it includes periodic reporting of mortality trends and responses to ensure public reporting regarding the health, welfare, and safety of program beneficiaries.

4. Quality Assurance Mechanisms That Ensure the Delivery and Fiscal Integrity of Appropriate Community-Based Services

A comprehensive quality assurance system of community-based services includes the incident management, audit, and mortality review components discussed above and certain other elements of quality assurance. The quality assurance system includes the oversight of individualized service planning and delivery; the enhanced oversight of, and support for, high-risk beneficiaries; the assessment of the inclusion of service beneficiaries into their community; initial certification reviews of all new service providers and support coordination agencies; periodic assessments of the performance of service providers and support coordination agencies; audits of provider workforce assurances and background checks; reviews of the provider network's capacity, stability, and accessibility; assessments of the fiscal integrity of service billing and reimbursement; and compliance monitoring related to Federal fiscal and programmatic requirements.

Collectively, these four compliance oversight components help ensure that beneficiary health, safety, and civil rights are adequately protected, that provider and service agencies operate under appropriate accountability mechanisms, and that public services are delivered consistent with funding expectations and commitments. Additionally, we hope adoption and implementation of the suggested Model Practices across the four critical element areas will ultimately inform larger quality improvement efforts related to delivery of home and community-based services and the experience of beneficiaries receiving these supports to realize community-living goals.

IV. CONCLUSION

OIG's audit work in this area is continuing in additional States. Media coverage and disturbing trends identified by advocacy organizations and protection and advocacy entities throughout the country continue to uncover terrible examples of abuse and neglect of Medicaid beneficiaries in group homes, nursing facilities, and hospitals.

OIG, ACL, and OCR make the following suggestions to help maintain independence, human dignity, choice, and self-determination for Medicaid beneficiaries; improve compliance with *Olmstead*; and ensure safety and a high quality of care for beneficiaries.

Based on OIG's audit work and work with the interagency group, OIG, ACL, and OCR suggest that CMS:

- encourage States to implement comprehensive compliance oversight systems for group homes, such as the Model Practices, and regularly report their findings to CMS;
- form a "SWAT" team to address, in a timely manner, systemic problems in State implementation of and compliance with health and safety oversight systems for group homes; and
- take immediate action in response to serious health and safety findings, for group homes using the authority under 42 CFR § 441.304(g).

APPENDIX A
Model Practices for State Incident Management and Investigation

This appendix sets forth the Model Practices for State Incident Management and Investigation. As detailed below, incident management and investigation involve providing immediate and effective responses to serious incidents to protect the involved beneficiary's safety and well-being and to mitigate reoccurrence.

I. Intended Outcomes of Incident Management and Investigation
II. Participants in State Incident Management and Investigation
III. Essential Components of State Incident Management and Investigation
IV. Detailed Elements of the Essential Components
  A. Reporting and Notifications
  B. Incident Reviews
  C. Investigations
  D. Corrective Action Recommendations and Implementation
  E. Trend Analysis

Attachment A: Suggested Data Elements for Incident and Investigation Database Systems

I. Intended Outcomes of Incident Management and Investigation

A. To ensure responses to serious incidents in community-based service systems that timely and effectively resolve the immediate event/situation (i.e., protecting the safety and well-being of the individuals involved and preventing a reoccurrence);

B. To ensure that the facts and circumstances of serious incidents are timely and effectively reviewed and investigated as required;

C. To ensure that trends and patterns regarding serious incidents are identified and addressed with appropriate recommendations for corrective actions (including but not limited to additional provider and staff training focused on both quality assurance and improvement, necessary changes and reforms to specific protocols in service delivery, and enhancements to standard operating policies);

D. To ensure that recommendations for corrective actions associated with serious incidents are timely and effectively implemented;

E. To ensure that implemented corrective actions are effective in preventing or reducing the occurrence of serious incidents;

F. To ensure that Government officials (Federal and State), provider and support coordination agencies, and designated protection and advocacy entities receive timely and effective notification of serious incidents; and

G. To ensure public reporting related to the overall safety and well-being of individuals supported by community-based service systems and support for the quality assurance of community-living options for individuals.

II. Participants in State Incident Management and Investigation

A. This model for State Incident Management and Investigation focuses on two main participants: service provider agencies and State officials.

B. Other primary reporters of incidents include service recipients, family members, and friends of service recipients, as well as support coordinators and advocates. Support coordinators and support coordination agencies also have primary roles in the immediate review of reported incidents and timely responses to health and safety issues for involved service recipients. On occasion, service providers may invite these participants to contribute to discussions of particular incidents at meetings of the provider's Incident Management Review Committee. These participants can provide valuable information in many incident investigations.

C. The Federal Government also has statutory roles of ensuring that States' incident management and investigation programs actually work as designed to ensure the accountable reporting, investigation, resolution, and prevention of serious events and situations that do or could jeopardize the health and welfare of service recipients. Additionally, the Federal Government should have the capacity to undertake independent incident investigations and audits of States' Incident Management and Investigation processes in response to State quality assurance reports, citizen complaints, and concerns that may surface in Medicaid or Medicare data. The Federal Government also has the unique capacity to identify and respond to trends in incidents and incident investigation findings across States and to use its observations to frame ongoing, needed quality improvements in the Federal regulatory framework for States' community-based service systems.

III. Essential Components of State Incident Management and Investigation

A. Reporting and Notification

B. Incident Review

C. Investigation

D. Corrective Action Recommendations and Implementation

E. Trend Analysis

IV. Detailed Elements of the Essential Components

A. REPORTING AND NOTIFICATIONS

1. Service Providers

   i. Service providers should ensure that all incidents are reported as soon as possible after discovery.

2. Support Coordinators and Support Coordination Agencies

   i. Support coordinators and support coordination agencies should be required to report to designated State officials any instances of failed incident reporting or failed external notifications of incidents.

3. Service Providers and the State

   i. Service providers and the State should ensure that individuals (including service recipients, staff, and family members) are free from retaliation or adverse consequences because they reported incidents or allegations of abuse, neglect, exploitation, or other staff misconduct or errors.

   Service providers should ensure that failed incident reporting and delays in incident reporting result in appropriate employee discipline, including employee suspension or termination.

   ii. The State should take assertive steps to identify patterns of failed incident reporting and delays in incident reporting by service providers. The steps should include reviews of incident reporting by service providers and support coordination agencies. These reviews should rely on cross-reference assessments of a variety of data sources (e.g., hospitalization and emergency room billing records, licensure or certification findings, grievance and complaint reports, and daily note documentation).

   The State should also ensure that it imposes appropriate sanctions against such providers, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.

4. Service Providers, Support Coordination Agencies, and the State

   i. The State, service providers, and support coordination agencies should ensure safeguards are in place to protect the confidentiality

of incident reports and any databases containing incident report information.

5. The State

   i. The State should disseminate and ensure appropriate training of service providers and support coordinators regarding what events, situations, and circumstances constitute reportable incidents. Reportable incidents should include:

      a. deaths;

      b. allegations of physical, psychological, or financial exploitation;

      c. allegations of physical or psychological neglect;

      d. allegations of physical or psychological abuse;

      e. allegations of sexual abuse;

      f. incidents involving the inappropriate restraint or seclusion of service recipients;

      g. events that lead to adverse consequences or outcomes to service recipients because of staff misconduct or error;

      h. events that result in injury or illness to a service recipient requiring medical treatment beyond first aid;

      i. choking incidents;

      j. hospital emergency room visits where the injury or the medical condition could indicate abuse or neglect, as well as unplanned hospitalizations of service recipients;

      k. service recipient elopements whereby the individual is removed from staff supervision or the individual is placed at risk of serious harm;

      l. behavioral incidents of a service recipient that result in (a) employee physical intervention with the service recipient including restraint, (b) serious risk of harm to the individual, other service recipients, employees, or community citizens, or (c) property damage valued at more than $150;

m. emergency situations, including fires, flooding, and serious property damage, that result in harm or risk of harm to service recipients;

n. financial exploitation or theft of a service recipient's property or funds of $25 or greater;

o. incidents that may involve criminal conduct by service recipients or employees; and

p. incidents involving law enforcement personnel.

ii. The State should identify criteria for ranking incidents by seriousness of harm or potential harm to service recipients.

iii. The State should implement policies requiring service providers to inform families or guardians and support coordinators about reported incidents as soon as possible after discovery and in all cases within 72 hours.

iv. The State should ensure that clarification is sent to service providers of any required external incident report notifications to other State officials or agencies (including law enforcement as applicable) for certain serious incidents, including deaths, allegations of abuse and neglect, and possible criminal acts.

v. The State should take assertive steps to identify patterns of failed or delayed external notifications of incidents by service providers and to ensure that it takes appropriate actions against such providers, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.

6. Federal Government

i. In the context of its overall role in protecting waiver service recipients from harm, the Federal Government should ensure reviews of accountable incident reporting by States. Such reviews include Federal oversight to ensure that States are conducting credible assessments of accountable incident reporting, as well as periodic federally directed assessments of incident reporting by service providers.

B. INCIDENT REVIEWS

1. States should set objective criteria to ensure that for those incidents that result in significant injury, service providers ensure a preliminary review by senior management and an immediate response to all incidents within 24 hours of their discovery.

2. Service providers should establish Incident Management Review Committees to ensure a comprehensive review of incidents and investigation findings. Every Incident Management Review Committee should:

    i. identify the facts surrounding incidents, including any contributing factors;

    ii. review investigations of reported incidents;

    iii. identify needed corrective actions or remedies to prevent or reduce the likelihood of future similar incidents;

    iv. review and either accept or reject the recommended corrective actions from investigations and mortality reviews of incidents;

    v. document in its official minutes all accepted recommendations and rationales for any rejected recommendations;

    vi. ensure that recommended corrective actions or remedies are implemented in a timely and appropriate manner; and

    vii. evaluate the outcomes of instituted corrective actions or remedies.

3. Service providers' Incident Management Review Committees should meet on a regularly scheduled basis (e.g., biweekly), except when none of the above-listed review activities are pending.

4. The State should establish a State Incident Management Review Committee, which should:

    i. reach out to adult protective services, protection and advocacy entities, and other partners that can provide data on the number and types of incidences reported in group homes and technical assistance and subject matter expertise to the committee's deliberations;

    ii. review particularly serious incidents (including substantiated reports of abuse and neglect and apparently preventable deaths);

iii. review the adequacy of State and provider investigations of serious incidents in accordance with the standards specific in Section C, Investigations, below;

iv. identify and review trends and patterns in reported incidents and the findings, conclusions, and recommendations in State investigations;

v. review annual reports of the trends and patterns in reported incidents and State investigations;

vi. identify and respond to State, regional, and other identified trends and patterns in incidents and State investigations; and

vii. discuss potential systems-wide corrective actions for improving quality assurance (including but not limited to additional training of providers and State personnel; necessary changes and reforms to specific protocols in service delivery, incidence reporting, and management; and enhancements to specific policies and provider requirements).

5. The State Incident Management Review Committee should meet regularly to ensure its review responsibilities are carried out in timely manner. Service providers and State Incident Management Review Committees should maintain appropriate minutes of their meetings, meeting attendees, their deliberations regarding incidents, and recommendations for corrective actions.

6. The State should ensure comprehensive oversight of the operation of the State's Incident Management and Investigation Program, including but not limited to periodic State-conducted reviews of the incident management and investigation activities of provider and support coordination agencies, State investigators, and the State's Incident Management Review Committee.

C. INVESTIGATIONS

1. The State should ensure independent State investigations of:

i. allegations of physical or emotional abuse and neglect that result in serious or repeated harm to service recipients;

ii. allegations of sexual abuse;

iii. allegations of financial exploitation in which the goods stolen are valued at more than $250 or thefts of lesser value occurring repeatedly;

iv. deaths that occurred unexpectedly or that appear or are alleged to be due to provider or support coordinator misconduct, abuse, or neglect;

v. incidents that result in potentially life-threatening or serious injury or illness that appear or are alleged to be due to provider or support coordinator misconduct, abuse, or neglect or that occurred under suspicious circumstances (e.g., repetitive ER visits, multiple uses of physical restraints per day);

vi. incidents that result in potentially life-threatening or serious injury that were due to environmental hazards (e.g., fires, drownings, serious automobile accidents, weather emergencies); and

vii. incidents that result in criminal charges or incarceration of service recipients or employees.

2. For serious incidents not described above, the State may (at its discretion) delegate the conduct of the investigations to provider or support coordination agencies or another authorized entity.

3. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, incident investigations involving allegations of physical abuse and neglect that result in death or potentially life-threatening or serious injury or illness should be completed within 14 days. When the 14-day timeframe cannot be met, the State should ensure that a designated senior State official reviews and approves timeframe extensions.

   All other incident investigations should be completed within 30 days. When the 30-day timeframe cannot be met, the State should ensure that a designated senior State official reviews and approves timeframe extensions.

4. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should ensure that all investigators have successfully completed a competency-based training program that meets generally accepted professional standards.

5. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should develop and ensure compliance with performance standards for conducting incident investigations. Such standards should include:

   i. a review of the person-centered service plan of the service recipient and other reported incidents in the past year;

ii. a review of the circumstances leading up to and following the incident;

iii. interviews with all witnesses to the incident (employees, service recipients, and community citizens);

iv. interviews with family members or guardians of the service recipient;

v. interviews with other relevant parties, including provider agency supervisory, management, and health care personnel and the assigned support coordinator for the service recipient;

vi. reports of the State protection and advocacy entity related to investigations of incidences that have occurred in group home settings;

vii. reviews of relevant documents and medical records maintained by the service provider, support coordinator, or external health care entities, including hospitals and outpatient medical providers; and

viii. reviews of law enforcement reports, death certificates, and autopsy reports (as available).

6. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should develop a standard template for incident investigation reports that includes sections related to:

i. findings and observations associated with all completed investigative activities,

ii. the investigation's conclusions, and

iii. the investigation's recommended corrective actions.

7. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should ensure appropriate reviews and approval of completed investigations by trained State personnel. Such reviews should include:

i. the investigation's compliance with the above investigation performance and format requirements and

ii. the appropriateness of the investigation's findings, conclusions, and recommendations.

8. The State should make reasonable efforts to ensure that State investigators and State investigation reviewers (including members of the State Incident Management Review Committee) have access to death certificates, autopsy reports, and medical and hospital records pertinent to the investigation of unusual, suspicious, sudden, or apparently preventable deaths.

9. The State should assure that administrative or legislative efforts, or both, will be made to ensure that autopsies are requested and conducted for deaths in which abuse or neglect is suspected or alleged or the circumstances of the death are unusual, suspicious, sudden, or apparently preventable.

10. The State should ensure the dissemination of appropriate summaries[7] of investigation findings, conclusions, and recommendations for corrective action to:

    i. relevant service provider personnel including employees directly associated with the incident,

    ii. the service recipient's support coordinator and support coordination agency, and

    iii. the service recipient and his or her family or friends (with consent of the individual service recipient or their legal guardian or legal representative if the service recipient is unable to provide consent).

D. CORRECTIVE ACTION RECOMMENDATIONS AND IMPLEMENTATION

1. The State should conduct a trend analysis of incidents and identify the specific incident types that would benefit from a systemic intervention.

2. The State should inform providers, support coordinators, and other stakeholders of recommendations for corrective actions, including any systemic interventions required as the result of trend analysis, and their responsibility to address such recommendations in a timely manner by implementing them or substantiating that they are unnecessary.

3. Providers and the State should maintain accountable tracking systems for all recommendations for corrective actions emanating from incident reviews and investigations. Such tracking systems should include accepted and rejected recommended corrective actions and ongoing status

[7] Summaries should be informative but protect the confidentiality of service recipients and individuals interviewed in the course of the investigation.

reporting of the implementation and date of accepted recommended corrective actions.

4. Providers, support coordination agencies, and the State should ensure that accepted recommended corrective actions are implemented within the required timeframes, and they should provide written documentation to the State justifying any implementation delay of more than 30 days.

5. The State should ensure ongoing monitoring of the implementation of accepted recommended corrective actions (via its tracking system) by service providers and the State.

6. Service providers identified as having recurring deficiencies in the timely implementation of accepted recommended corrected actions should be subject to State actions, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.

7. Service providers and the State should periodically, at least annually, review their corrective action tracking systems to evaluate:

   i. the systems' overall performance in ensuring the timely implementation of accepted recommended corrective actions and

   ii. the effectiveness of implemented corrective actions to achieve the intended outcomes.

E. TREND ANALYSIS

1. Service providers and the State should ensure timely entry of data into the Incident and Investigation Database Systems. Those data should include:

   i. incident reports;

   ii. findings and recommendations of their Incident Management Review Committees;

   iii. findings and recommendations of State incident investigations; and

   iv. the status of corrective actions. (See Attachment A for specific recommended data elements to be included in Incident and Investigation Database Systems.)

2. Using their Incident and Investigation Database Systems, service providers are responsible for identifying trends and patterns in filed incidents and the findings and recommendations of their Incident Management Review Committees and State investigations involving their service recipients.

3. Service providers should ensure on a quarterly basis that identified trends and patterns are shared with their Incident Management Review Committees. Service providers should provide to the State an annual report of identified trends and patterns in their incidents, incident review findings and recommendations, and State incident investigations.

4. Using their ongoing and annual trend analysis activities, service providers are responsible for identifying needed additional corrective actions (including systemic actions) and for ensuring that they are implemented in a timely manner.

5. The State is responsible for ensuring that service providers comply with the above trend analysis requirements, including their obligation to identify and implement needed additional corrective actions to address adverse trends and patterns in service recipient protection and safety.

6. Using the State Incident and Investigation Database System, as well as providers' annual trend analysis reports, the State should at least biennially conduct its own trend analysis of reported incidents, the findings and recommendations of the State's Incident Management Review Committee, and the findings and recommendations of State investigations. Reports of these analyses, after the deletion of any personally identifiable information, should be available to the public to ensure the transparency of the State's Incident Management and Investigation program. Based on this analysis, the State should identify and implement any additional corrective actions that are needed. Such additional recommendations may address:

   i. needed state-wide remedies,

   ii. needed regional remedies, and

   iii. needed remedies for select groups of service recipients and providers.

Attachment A

Suggested Data Elements for Incident and Investigation Database Systems

- Name (or identification number) of individual involved
- Incident report identification number
- Date the incident occurred
- Provider agency
- Region (administrative waiver region)
- Location of incident (e.g., residential home, own home with family, day program site, community location)
- Age of the individual involved
- Sex of the individual involved
- Race or ethnicity of the individual involved
- Type of disability
- Type of incident (use a standardized list with definitions)
- Level of harm or injury to the individual: (i) none, (ii) injury or harm requiring treatment up to and including first aid, (iii) injury or harm requiring medical treatment beyond first aid, injury or harm requiring hospitalization, and (iv) injury or harm resulting in death
- Narrative description of the incident (fairly detailed narrative description of up to 150 words)
- Service provider or service provider's Incident Management Review Committee investigative findings and recommendations
- Incident referred for State investigation (yes/no)
- Date of the State Incident Management Review (if applicable)
- Findings and recommendation of the State Incident Management Review Committee (narrative field of up to 150 words) (if applicable)
- Date of State investigation (if applicable)

- State investigation substantiated physical abuse (yes/no)
- State investigation substantiated neglect (yes/no)
- State investigation substantiated sexual abuse (yes/no)
- State investigation substantiated exploitation (yes/no)
- State investigation substantiated psychological or verbal abuse, or both (yes/no)
- State investigation substantiated other form of staff misconduct not associated with abuse, neglect, or exploitation (yes/no)
- Incident is identified in trending analysis (yes/no)
- Narrative description of State investigation findings, recommendations, and corrective actions (narrative field of up to 150 words) (if applicable)
- Narrative fields that track recommendation implementation and corrective action relevant to State Incident Management Review Committee and State investigation recommendations and corrective actions (optional)

APPENDIX B
Model Practices for Incident Management Audits

This appendix sets forth the Model Practices for Incident Management Audits. As detailed below, effective incident management auditing involves processes to assess timely and appropriate incident reporting, investigation, and response and for implementation of timely and appropriate corrective actions to minimize reoccurrence.

I. Major Components
II. Audit Expectations
III. Audit Performance Measures
  A. Incident Reporting and External Notifications
  B. Individual Incident Review
  C. Incident Investigations
  D. Implementation and Effectiveness of Corrective Actions
  E. Systemic Incident Review for Trends and Patterns
IV. Incident Documentation Audits
  A. Audit Sample
  B. Audit Reporting, Compliance Scoring, and Corrective Actions
  C. Audit Methods
V. Medicaid Data Correlation Audits
  A. Sample Requirements
  B. Audit Reporting, Compliance Scoring, and Corrective Actions
  C. Audit Methods

I. Major Components

The Incident Management Audit process has two components designed to assess, each from different perspectives, the basic expectations and performance measures of a State's Incident Management and Investigation activities.

A. The Incident Documentation Audit is an audit of a sample of incident reports, incident investigations, and other documents (i.e., protection and advocacy complaint data) and documentation associated with incidents for all service recipients in currently approved and operational CMS-funded community programs. The Incident Documentation Audit can be conducted at the Federal or State levels as part of waiver applications or renewals. In response to complaints or other concerns, CMS or States can conduct selected elements of an Incident Documentation Audit. This type of audit focuses on the State's actions to incidents that were reported.

B. The Medicaid Data Correlation Audit is an audit of Medicaid service claim data to determine if (as appropriate) incident reports were filed, incident investigations and reviews were conducted, and appropriate corrective actions were recommended and implemented in a timely manner in response to serious

incidents requiring health care services at a hospital emergency room or in other areas of the hospital. This audit evaluates whether serious incidents associated with hospital emergency room visits and unplanned hospitalizations were reported.

II. Audit Expectations

Incident Management Audits address five major expectations of a State's Incident Management and Investigation activities:

1. Accountable incident reporting and external notifications of serious incidents
2. Timely and appropriate response and review of individual incidents
3. Timely, comprehensive, and nonpartial investigations of individual incidents
4. Timely implementation of appropriate corrective actions in response to individual incidents
5. Informative systemic review of incidents to identify, address, and respond to trends and patterns in incidents

III. Audit Performance Measures

A. ACCOUNTABLE INCIDENT REPORTING AND EXTERNAL NOTIFICATIONS OF SERIOUS INCIDENTS

1. Documentation shows that service providers and support coordination agencies have an appropriate understanding of what events and situations should be reported as incidents.
2. Incident reports for incidents resulting in significant injuries are filed as soon as possible, but in all cases within 24 hours.
3. Incident reports provide a clear, complete, and legible description of the incidents.
4. Incident reports (or associated documentation) provide a description of the provider's immediate response to the incidents.
5. The documented providers' immediate responses to incidents ensure service recipients' safety and well-being.
6. Incident reports (or associated documentation) show that law enforcement was notified of incidents that may be associated with possible criminal acts as soon as possible.

7. Incident reports (or associated documentation) show that in accordance with State rules and regulations other external parties (including but not limited to family, conservators, guardians, the State's Medicaid agency, and the State's protection and advocacy entity) or other appropriate parties were notified of incidents in a timely manner.

8. Documentation shows that the State identifies and imposes appropriate sanctions against service providers, support coordination agencies, and others that are identified as having a pattern of *not* complying with the above performance measures related to incident reporting and notifications.

B. INDIVIDUAL INCIDENT REVIEW

1. Incident reports (or associated documentation) show that providers ensure a timely review of all incidents by senior management or the provider's Incident Management Committee or both.

2. The meeting minutes from a service provider's Incident Management Committee show that the committee reviews all incidents in accordance with CMS expectations as described in the State's approved HCBS waiver application and the State's regulatory and policy requirements.

3. The meeting minutes from a service provider's Incident Management Committee show that the committee meets as frequently as needed to ensure the timely review of incidents.

4. The meeting minutes from a service provider's Incident Management Committee show that the Committee is composed of appropriate members consistent with CMS expectations as described in the State's approved HCBS waiver application and the State's regulatory and policy requirements.

5. The meeting minutes from a service provider's Incident Management Committee show that the committee thoroughly reviews incidents and associated investigations such that the committee:

    i. identifies the facts surrounding incidents as well as the contributing factors associated with incidents;

    ii. reviews incident investigation reports and discusses their findings and recommendations;

    iii. considers additionally needed corrective actions and remedies to prevent or reduce the likelihood of future similar incidents;

    iv. explicitly accepts or rejects the recommended corrective actions in investigations; and

v. tracks accepted recommended corrective actions to ensure that they are carried out in a timely manner.

6. The meeting minutes from a service provider's Incident Management Committee provide a listing of all incidents reviewed and an adequate summary of the committee's findings and recommendations and other activities of the committee.

7. Documentation shows that the State identifies and imposes appropriate sanctions against service providers that are identified as having a pattern of *not* complying with the above performance measures related to incident reviews and Incident Management Committees.

C. INCIDENT INVESTIGATIONS

1. Documentation indicates that independent investigations are ensured for all incidents associated with unexpected deaths; allegations of physical, emotional, and sexual abuse; allegations of neglect; allegations of financial exploitation (> $250); and other serious incidents as required by State rules and regulations.

2. Documentation indicates that investigations are completed within 30 days of the date the incident report was filed, except in instances when supplemental documentation indicates a justifiable rationale for the delay in the completion of the investigation.

   Examples of a justifiable rationale include delays because of an ongoing law enforcement investigation or the unavailability of an important witness because of serious illness or injury.

3. Documentation indicates that investigations are conducted by investigators who have completed a certified investigator training program approved by CMS as described in the State's approved HCBS waiver application, the State, or both.

4. Documentation indicates that investigations include basic required investigative activities, including:

   i. a review of the person-centered service plan of the service recipient and other reported incidents in the past year;

   ii. a review of the circumstances leading up to and following the incident;

   iii. interviews with all witnesses to the incident (employees, service recipients, and other individuals in the community);

iv. interviews with family members or guardians of the service recipient (with the consent of the service recipient or his or her legal guardian or legal representative if the recipient is unable to provide consent)

v. interviews with other relevant parties, including provider agency supervisory, management, and health care personnel and the assigned support coordinator for the service recipient;

vi. reviews of relevant documents and medical records maintained by the service provider, support coordinator, protection and advocacy entities, or external health care entities, including hospitals and outpatient medical providers; and

vii. reviews of law enforcement reports, death certificates, and autopsy reports (as available).

5. Investigation reports are prepared using a standard format complying with any standards established by CMS that ensures discrete narratives related to (i) a listing of the investigative activities, (ii) findings and observations associated with all completed investigative activities, and (iii) the investigation's conclusions and recommendations.

6. Investigation reports indicate that investigators have access to and review death certificates, autopsy reports, and medical and hospital records pertinent to incidents being investigated.

7. Investigation reports indicate that autopsies are requested and conducted for deaths where abuse or neglect is suspected or alleged and other deaths caused by suspected provider or support coordinator misconduct.

8. Appropriate summaries of investigation findings, conclusions, and recommendations for corrective action are prepared and made available to:

i. relevant service provider personnel, including employees directly associated with the incident;

ii. the service recipient's support coordinator and support coordination agency;

iii. the service recipient and his or her family and friends (with the consent of the service recipient or his or her legal guardian or legal representative if the service recipient is unable to provide consent); and

iv. the State protection and advocacy entity.

9. Documentation indicates that the service recipient or their legal guardian or legal representative have had the opportunity to review the investigation findings, conclusions, and recommendations and have had the opportunity to respond to any investigation findings through a predetermined grievance process under the State HCBS waiver authority.

10. Documentation indicates that the State identifies and imposes appropriate sanctions against service providers that are identified as having a pattern of *not* complying with the above performance measures related to incident investigations.

D. IMPLEMENTATION AND EFFECTIVENESS OF CORRECTIVE ACTIONS

1. Documentation indicates that service providers, support coordination agencies, and other pertinent individuals or entities take timely and effective actions to implement recommendations for corrective actions related to individual incidents.

   Timely is defined as "as soon as possible" and within 30 days in all cases except where a written reasonable justification for the delayed implementation is available.

2. Documentation indicates that the State maintains an accountable tracking system to monitor the implementation of recommendations for corrective actions emanating from incident reviews and investigations.

3. Documentation indicates that the State ensures appropriate methods to verify (on a sample basis) that the recommendations for corrective actions from the reports of service providers, support coordination agencies, and others were in fact implemented.

4. Documentation indicates that the State identifies and imposes appropriate sanctions against service providers, support coordination agencies, and others that are identified as having a pattern of *not* responding to recommended corrective actions in a timely and effective manner.

E. SYSTEMIC INCIDENT REVIEW FOR TRENDS AND PATTERNS

1. Meeting minutes from a service provider's Incident Management Committee or other documentation and reports indicate that the service provider periodically, at least annually, reviews incident data, including investigative findings and recommended corrective actions. The review is to identify trends and patterns in filed incidents as well as noncompliance issues related to the State's regulatory and policy requirements for incident management.

2. Meeting minutes from a service provider's Incident Management Committee or other documentation and reports indicate that identified trends and patterns (as referenced above) are addressed in a timely and appropriate manner.

3. Meeting minutes from a service provider's Incident Management Committee or other service provider documentation and reports indicate that the service provider periodically evaluates actions taken in response to identified trends and patterns to ensure that they have been effective in addressing identified problems and concerns.

4. State documentation or reports indicate that the State regularly reviews trend and pattern analyses reports prepared by service providers and takes appropriate actions to respond to issues and concerns affecting the health and welfare of service recipients.

5. State documentation or reports indicate that the State periodically conducts state-wide incident studies to identify trends and patterns in reported incidents and investigation findings and that it takes appropriate actions to respond to identified issues and concerns affecting the health and welfare of service recipients.

IV. Incident Documentation Audits

A. AUDIT SAMPLE

1. The Incident Documentation Audit is based on the review of a sample of incident reports filed in the first quarter of the 12-month period before the date of the State's submittal of a new waiver application or a renewal waiver application.[8] These samples include:

   i. all unexpected deaths;

   ii. all allegations of physical or sexual abuse;

   iii. all allegations of financial exploitation for amounts greater than $250;

   iv. a statistically significant random sample of allegations of neglect;

   v. a statistically significant random sample of other "serious" incidents (not included above); and

[8] Multiple Incident Documentation Audits are not necessary for States that submit multiple new waiver applications or waiver renewal applications within a 3-year period.

vi. a statistically significant random sample of "nonserious" incidents.

B. AUDIT REPORTING, COMPLIANCE SCORING, AND CORRECTIVE ACTIONS

1. States should report to CMS Incident Documentation Audit findings in aggregate across all of the above samples as well as separately for each of the above samples.

2. States should also report their Incident Documentation Audit findings by Medicaid regional administration units. Additionally, as applicable, findings should identify service providers that demonstrate an increase in incidences or a pattern of noncompliance with incident reporting and other expectations of Incident Management Programs.

3. States should report their Incident Documentation Audit findings to CMS at least 90 days before the date it submits its new or renewal waiver application.

4. Findings reports should be presented to CMS to provide discrete compliance scores for each of the performance measures of Incident Management processes detailed above.

5. For all performance measures (detailed above), an 86-percent compliance score is expected. States should develop and implement plans of correction for all performance measure scores of less than 86 percent before CMS's approval of new or renewal waiver applications.

6. Failure to implement appropriate corrective actions for substandard compliance scores may result in CMS sanctions, including but not limited to adverse decisions on new or renewal waiver applications.

7. At its discretion, CMS may impose immediate sanctions against States whose Incident Documentation Audits result in poor compliance scores or selected negative results that indicate that its waiver service recipients may be at risk of imminent harm.

C. AUDIT METHODS

1. States should rely on their electronic Incident and Investigation Database to select the required audit samples.[9] The sample selection methods will be explicitly presented in reports of the audit findings.

[9] The audit protocol assumes that all States have an electronic Incident Database.

2. Once incident samples are selected, the State (with the assistance of service providers and support coordinators) will gather required documents and documentation for the audit.

   Such documents and documentation should include:

   i. reports of the incidents and any associated investigations;

   ii. copies of any associated daily service notes or other documentation associated with the incident report;

   iii. any meeting minutes from service providers' Incident Management Committees that are associated with the sample incidents;

   iv. other documentation maintained by service providers associated with the sample incidents, including their responses, reviews, and corrective actions;

   v. documentation and reports of service providers associated with the sample incidents related to their periodic reviews of incidents and investigations to identify trends and patterns;

   vi. documentation of the State verifying its ongoing review of service providers' reports related to the providers' reported trends and patterns in incidents and investigations; and

   vii. State documentation and reports associated with its periodic reviews of incidents state-wide to identify trends and patterns.

3. This documentation should be sorted and reviewed in accordance with the performance measures listed earlier, and findings should be documented on a standardized audit tool developed and approved by CMS as described in the State's approved HCBS waiver application.

4. In addition to the above documentation, States should collect and review any documentation associated with its ongoing monitoring of the compliance of service providers and support coordination agencies with the major expectations and performance measures for Incident Management processes.

   Such documentation should include sanctions taken against service providers and support coordination agencies that demonstrate patterns of noncompliance.

5. To ensure the integrity of Medicaid Data Correlation Audits, CMS and States should maintain copies (paper or electronic) of all documentation collected and audit tools for at least 5 years.

6. States should ensure that the audit team is composed of professionals knowledgeable about incident management systems and their expectations and performance measures. These professionals should also be independent of State personnel charged with the direct implementation or management of the State's Incident Management processes.[10]

   In concert with the above requirements, States should maintain current curriculum vitae of all professionals on their audit teams.

7. To preserve nonbiased audit findings and conclusions, States should ensure the explicit tracking of any alterations or substantive edits of draft reports of Incident Documentation Audits.

8. To ensure the timeliness and the relevance of their findings and conclusions, Incident Documentation Audits should be completed within 90 days of their initiation.

V. Medicaid Data Correlation Audits

A. SAMPLE REQUIREMENTS

1. Medicaid Data Correlation Audits should rely on samples of Medicaid service data related to waiver recipients.

   The audit team should review these data to identify service reports that would appear to have warranted the filing of an incident report.

2. Medicaid Data Correlation Audits may be directed by CMS or States (either voluntarily or as required by CMS).

3. Medicaid Data Correlation Audits should focus on waiver service recipients whose care and supports are largely the responsibility of paid service providers, not family members or friends. These recipients should include:

   i. individuals in residential services,

   ii. individuals who receive in-home paid staff supports at least 40 hours a week, and

   iii. individuals who receive day services at least 20 hours a week.[11]

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[10] States may at their discretion contract out Incident Documentation Audits to independent consultants or consultant organizations that meet the above-listed requirements.

[11] This restriction is included because States do not usually require the reporting of incidents involving service recipients while in the care of family or friends.

4. Medicaid services data to be screened should include services associated with:

   i. Allegations of abuse, neglect and/or exploitation;

   ii. hospital emergency room visits;

   iii. unplanned hospitalizations;

   iv. ambulance services; and

   v. urgent care center visits caused by accidental injuries.[12]

5. The time period for the data collected may vary based on the size of the applicable waiver service recipient sample population, but at a minimum it should include Medicaid services data for at least one quarter of a calendar year.

B. AUDIT REPORTING, COMPLIANCE SCORING, AND CORRECTIVE ACTIONS

1. Findings of Medicaid Data Correlation Audits should include state-wide findings as well as findings by Medicaid regional administration units (within the State).

   Additionally, as applicable, findings should identify service providers that demonstrate a pattern of noncompliance with incident reporting and other expectations of Incident Management processes.

2. Finding reports should provide discrete compliance scores for each of the performance measures of Incident Management processes detailed above.

3. For all performance measures, CMS should establish an 86-percent compliance score. CMS should require States to develop and implement plans of correction for all performance measure scores of less than 86 percent before CMS approves any new or renewal waiver applications.

4. Failure to implement appropriate corrective actions for substandard compliance scores may result in CMS sanctions, including but not limited to adverse decisions on new or renewal waiver applications.

5. At its discretion, CMS may impose immediate sanctions against States whose Medicaid Data Correlation Audits result in poor compliance scores

[12] CMS may also wish to include service reports for individual waiver service recipients who have exceptionally high State Medicaid billings, exclusive of billings for State plan nursing, health aide, and clinical therapy or behavior support services.

or selected negative results that indicate that its waiver service recipients may be at risk of imminent harm.

C. AUDIT METHODS[13]

1. CMS and States should rely on States' state-wide Medicaid databases to draw the samples of Medicaid services data. The sample selection methods should be explicitly presented in the report of the audit findings.

2. Once the Medicaid services data are retrieved, CMS or the States should organize the data by service recipient and check the state-wide Incident and Investigation Database to determine which services have a corresponding incident report.

3. *For services data that have a corresponding incident report*, CMS or the States *should* request the provider agencies filing the report to submit documentation related to the incident and the provider(s)'s response to the incident.

   Such documentation should include:

   i. a copy of the incident report and any associated investigations;

   ii. a copy of any associated daily service notes or other documentation (including internal provider staff shift communication notes) associated with the incident/Medicaid service report;

   iii. meeting minutes from service providers' Incident Management Review Committee that are associated with the sample incidents;

   iv. other documentation maintained by service providers associated with the sample incidents, including the providers' responses, reviews, and any corrective actions; and

   v. documentation and reports of service providers associated with the sample incidents related to the providers' periodic reviews of incidents and investigations to identify trends and patterns.

4. This documentation should be sorted and reviewed in accordance with the above-stated performance measures. The findings should be documented on a standardized audit tool developed and approved by CMS.

5. *For services data that do not have a corresponding incident report*, CMS or the States should request explanations for the lack of a report from the

[13] As referenced above, CMS may itself conduct Medicaid Data Correlation Audits. Alternately, States may conduct their own Medicaid Data Correlation Audits, either voluntarily or as required by CMS.

State, provider agencies, or service providers, as well as any other available documentation indicating that the incident received an appropriate response.

6. To assure the integrity of Medicaid Data Correlation Audits, CMS and the States should maintain copies of all documentation collected and audit tools for at least 3 years.

7. CMS or the States should ensure that the audit team is composed of professionals knowledgeable about incident management systems and their expectations and performance measures.

8. When States conduct their own Medicaid Data Correlation Audits, States should ensure that members of the audit team are independent of State personnel charged with the direct implementation or management of the State's Incident Management processes.[14]

   In concert with the above requirements, States should be required to maintain current curriculum vitae of all professionals on the audit teams.

9. In addition, if States are conducting their own Medicaid Data Correlation Audits to preserve the nonbiased audit findings and conclusions, States should ensure the explicit tracking of any alterations or substantive edits of initially prepared draft reports of Incident Documentation Audits.

10. To ensure the timeliness and relevance of their findings and conclusions, Medicaid Data Correlation Audits should be completed and made publicly available within 120 days of their initiation.

[14] States may at their discretion contract out Incident Documentation Audits to independent consultants or consultant organizations that meet the above-listed requirements.

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APPENDIX C
Model Practices for State Mortality Reviews

This appendix sets forth the Model Practices for State Mortality Reviews. As detailed below, effective mortality reviews involve timely reporting of all beneficiary deaths, including identification of the cause of death and the circumstances contributing to or associated with the death.

I. Intended Outcomes of State Mortality Reviews
II. Essential Participants and Activities for State Mortality Reviews
III. The State Mortality Review Database

I. Intended Outcomes of State Mortality Reviews

A. Accountable and timely reporting of all service recipient deaths

B. Identification of the causes of deaths

C. Identification of the immediate and longer term (up to 12 months before the death) circumstances and events that contributed to or were associated with deaths

D. Identification of corrective actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths

E. Identification of trends and patterns in deaths that indicate needed systemic changes or reforms in community-based services that may reduce the risk of death and other adverse outcomes for service recipients

F. Appropriate and timely implementation of identified corrective actions and systemic changes and reforms to reduce the risk of death and other adverse outcomes for service recipients

G. Ongoing evaluation to ensure that implemented corrective actions and systemic changes or reforms have been effective in reducing the risk of death and other adverse outcomes for service recipients

H. Periodic public reporting on the number, causes, and circumstances of deaths to ensure public transparency regarding the health, welfare, and safety of beneficiaries of community-based services

II. Essential Participants and Activities for State Mortality Reviews

A. State Mortality Review processes should ensure the accountable and timely reporting of deaths, including checks on service provider and support coordination agencies' death reporting practices.

Service provider and support coordination agencies identified as having a pattern of delayed or failed death reporting or of filing reports that are misleading or incomplete should be subject to State sanctions, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.

B. State Mortality Review processes should ensure a preliminary review of the cause and circumstances of *all* reported deaths and identify the deaths warranting further State investigation and review. Such preliminary death reviews should be completed within 1 week of the date the death was reported.

As necessary, preliminary death reviews will include followup contact with the service provider(s) and support coordinator for additional information. Generally, preliminary death reviews will often occur before the State's receipt of the death certificate. Preliminary death reviews should not be officially closed until the death certificate has been received and reviewed.[15]

C. State Mortality Review processes should ensure State investigations of deaths that are determined upon preliminary review to be unusual, suspicious, sudden and unexpected, or apparently preventable, including all deaths alleged or suspected to be associated with neglect, abuse, or criminal acts.

State death investigators should have a professional medical background (e.g., registered nurse, certified nurse practitioner, physician assistant, and physician) and have completed a nationally certified training program for conducting critical incident (including death) investigations.

D. State Mortality Review processes should include a State Mortality Review Committee that has responsibility for comprehensive review of deaths identified as being unexpected, sudden and unusual or unnatural, caused by suspicious circumstances, associated with suspected or alleged provider misconduct or abuse or neglect, or any combination of these.

E. State Mortality Review processes should ensure that their comprehensive death reviews include the review of relevant records and documents associated with the death, including:

[15] Death certificates are often not available from State health departments until 90 days after the death, and autopsy reports are often not available until 120 to 180 days after the death.

1. service provider and support coordinator documentation, including (a) the person-centered service plan for the individual who is deceased, (b) notes related to service delivery (by both waiver and nonwaiver providers), and (c) any other service provider or State reviews or investigations of the death;

2. incident reports related to the deceased in the 6 to 12 months before death;

3. death certificates;

4. autopsy and medical examiner or coroner reports;

5. emergency medical personnel reports and documentation;

6. medical records including physicians, specialists, hospital, and emergency room records related to the individual who is deceased in the 6 to 12 months before death;

7. records and documentation of medical professionals who treated the individual who is deceased within 6 months of his or her death; and

8. as available, any State or other agency investigation of the death.

F. State Mortality Review processes should include working with other State and local authorities to establish protocols and procedures (including guardian or family caregiver consent) to ensure that the above-listed documents are made available in a timely manner.[16]

G. State Mortality Review processes should ensure that autopsies are requested and performed for all deaths deemed to be unusual or suspicious or without a known cause of death, including all deaths whose circumstances suggest possible neglect, abuse, or criminal conduct.[17]

H. State Mortality Review processes should ensure that State Mortality Review Committees establish appropriate procedures and practices to ensure that:

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[16] It is typically neither effective nor efficient to require service providers and support coordination agencies to gather death certificates, autopsies, and other medical records essential for the completion of comprehensive death reviews, as most often State officials have (or can obtain more readily) authorization to obtain these documents.

[17] Uniformly ensuring autopsies as referenced above is frequently challenging. Families often do not wish to have autopsies performed. Medical examiners and coroners often refuse to perform autopsies of "natural" deaths regardless of the circumstances or the lack of a clear cause of death. And autopsies are costly and most States do not have a mechanism for reimbursing localities for these costs. Thus, State Mortality Review processes should make extra efforts in working with other State and local authorities to promote the conduct of autopsies of deaths that meet the above criteria.

1. the committee's membership includes an interdisciplinary group of medically credentialed and other professionals (including providers and advocates) who are knowledgeable of community-based services;

2. the committee relies on explicit criteria to identify deaths that should be afforded comprehensive reviews by the committee;

3. the committee meets sufficiently frequently to guarantee the timely and comprehensive reviews of all required deaths; and

4. the committee members have timely access to all necessary documents and reports to assure comprehensive review of all required deaths.

I. State Mortality Review processes should track service provider and support coordination agencies' implementation of recommendations for corrective actions emanating from the State's Mortality Review Committee.

Although such tracking systems may rely primarily on service provider and support coordination agencies' written reports of corrective actions taken, State Mortality Review processes should also require periodic onsite reviews to ensure that reported corrective actions have been appropriately implemented.

J. State Mortality Review processes should ensure that appropriate actions (including fines, suspension of permission to enroll new participants, and waiver contract termination and decertification) are imposed against service providers and support coordination agencies found to have patterns of delayed or failed implementation recommendations issued by the State Mortality Review Committee.

K. State Mortality Review processes should periodically, but at least biennially, evaluate the effectiveness of implemented recommendations for corrective actions to reduce the death rate (total, by cause, by provider) or to achieve other positive outcomes for service recipients or the service system (e.g., reduced emergency room visits, hospitalizations, and critical incidents).

L. State Mortality Review processes should periodically, but at least biennially, do a trend analysis of deaths and issue any systemic interventions to ameliorate the conditions that resulted in the trend.

M. State Mortality Review processes should provide at least biennial public reporting on the number, causes, and circumstances of deaths of individuals receiving community-based services, including the trends and patterns identified by the State Mortality Review process.

III. The State Mortality Review Database

A. State Mortality Review processes should establish a State Mortality Review Database that, at a minimum, includes the following data elements:

1. name, age, race or ethnicity, disability type, and sex of the individual who is deceased;

2. community-based (waiver) services received by the deceased individual and the name(s) of the service provider(s);

3. narrative of the events leading up to the individual's death and the immediate circumstances of the death;

4. location of the death (e.g., individual's home, established day program, community setting, hospital emergency room, hospital, and hospice facility);

5. immediate and secondary causes of death;

6. if the death was . . .

    i. expected due to a known terminal illness;

    ii. associated with a known chronic illness;

    iii. a sudden, unexpected death;

    iv. due to unknown cause

    v. due to an accident and, if so, the type of accident;

    vi. due to self-inflicted injury or illness (e.g., suicide, serious self-injurious behavior);

    vii. due to suspicious or unusual circumstances; and

    viii. due to suspected or alleged neglect, abuse, or criminal activity.

7. whether an autopsy was conducted and, if so, a narrative of its findings;

8. findings of the *preliminary* reviews of all deaths by the State Mortality Review process;

9. findings and recommended corrective actions of the *comprehensive* death reviews by the State Mortality Review Committee of selected deaths as defined above; and

10. tracking information related to the implementation of recommended corrective actions issued by the State Mortality Review Committee.

B. State Mortality Review processes should make use of the State Mortality Review Database to identify trends and patterns in:

1. the demographics of the deceased individuals, their community (waiver) services, and their providers;

2. causes of death;

3. total death rates and death rates by cause of death, geographic region, and service provider per total number of service recipients with the same demographics;

4. a comparison of death rates with national mortality statistics and available mortality statistics for comparable community-based services in other States;

5. circumstances of death;

6. findings and recommendations of the State Mortality Review Committee; and

7. the appropriate implementation of recommendations issued by State Mortality Review Committees by service providers, support coordination agencies, and the State (as applicable).

APPENDIX D
Model Practices for State Quality Assurance

This appendix sets forth the Model Practices for State Quality Assurance. As detailed below, comprehensive quality assurance of community-based services includes the incident management, audit, and mortality review components discussed above and certain other elements of quality assurance.

I. Essential Components of State Community-Based Services Quality Assurance
II. Quality Assurance Participants
III. Basic Operational Tasks of Quality Assurance
IV. Surveillance Capacities

I. Essential Components of State Community-Based Services Quality Assurance

A. A critical incident management and investigation process

1. Is ongoing

B. Mortality reviews

1. Are ongoing

2. Are conducted by State committees or external contractors

C. Oversight of individualized service planning and delivery

1. Emphasizes person-centered planning

2. Emphasizes individualized and relevant goals

3. Emphasizes appropriate service recommendations

4. Emphasizes practical action steps or interventions

5. Includes random onsite service recipient audits annually that cover either 10 percent of waiver enrollees or a statistically significant sample (whichever is larger) of waiver enrollees

D. Identification and timely intervention for high-risk service recipients

1. Includes ongoing clinical crisis management and prevention services

E. Assessment of community inclusion outcomes for service recipients

1. Periodic onsite audits of community day services and employment services

F. Initial certification reviews of all new service providers and support coordination agencies

1. Mandated initial reviews that must be passed before the start of waiver service delivery

G. Assessment of service provider and support coordination agency performance

1. Are consistent with regulatory and professional standards

2. Are periodic, at least biennial, audits of providers of:

i. residential services,

ii. day services,

iii. employment, and

iv. personal care, nursing, behavioral support, and support coordination[18]

H. Audits of workforce safeguard assurances by providers

1. Include assessments of pre-employment screening and background checks

2. Include assessments of staff training

3. Include assessments of performance evaluation

4. Are periodic, at least biennial, audits of providers of:

i. residential services,

ii. day services,

iii. employment, and

iv. personal care, nursing, behavioral support, and support coordination[19]

I. Reviews of a provider's network adequacy in terms of capacity, stability, and service accessibility

1. Are annual State assessments, including service gap analyses

[18] Some States allow providers and support coordination agencies that have least 2 years of operation within the waiver program and strong performance records to conduct these audits triannually.

[19] Workforce safeguard audits may be incorporated in service provider and support coordination audits. They are listed separately because it is often more efficient to conduct these audits with teams of specialized auditors.

2. Have stakeholder participation

J. Assessment of the fiscal integrity of service billing and reimbursement

1. Includes ongoing State desk audits

2. Includes periodic onsite audits of select service providers and support coordination agencies

K. Compliance monitoring related to Federal fiscal and programmatic requirements

1. Includes State desk audits of mandated reporting by service providers and support coordination agencies,

2. Includes ongoing onsite audits of select service providers and support coordination agencies

L. Reports or reviews issued by any local or State protection and advocacy entity related to complaints about abuse and neglect of individuals residing in group homes

II. Quality Assurance Participants

A. Service recipients, family members, friends, legal conservators, or guardians

B. Advocates

C. Protection and advocacy entities

D. State Councils on Developmental Disabilities

E. University Centers for Excellence in Developmental Disabilities

F. Service providers

G. Case Management or Support coordination providers

H. State government administrators of the Community-Based Service System

I. Federal Government administrators of the Community-Based Service System

J. Typically these participants work together in developing and implementing a State's quality assurance process, but each participant group also has certain primary roles in the process:

1. Service recipients, families, and friends offer primary data regarding their personal experiences and satisfaction with the Community-Based Service System. They may also provide information to other participants in the quality assurance process in structuring and evaluating their quality

assurance activities. They also give information to the State through the grievance and appeal process and satisfaction surveys of how the Community-Based Service System affects the individual (e.g., adequacy of provider network, availability of services, choice of provider and services).

2. Advocates, including Disability Rights organizations, local or state-wide advocacy groups, protection and advocacy entities, State councils on developmental disabilities, and consumer advocacy associations, offer independent advice related to their views of emerging and ongoing quality assurance issues in the Community-Based Service System.

3. Universities, including University Centers for Excellence in Developmental Disabilities, can be a source for training and technical assistance to providers that will increase their capacity. Universities can also serve as a resource for establishing incident reporting systems and for establishing processes for analyzing information to identify trends.

4. Service providers and support coordination providers have an obligation to institute internal quality assurance auditing activities to evaluate their performance (including service recipient and family satisfaction) relative to regulatory and professional standards.

   Robust and accountable internal quality assurance auditing programs developed and implemented by providers are the critical and often undervalued foundation of an accountable and effective quality assurance process for State's Community-Based Service System.

5. State government administrators have the overall quality assurance oversight obligation for:

   i. service recipient health, well-being, and safety and

   ii. the service system's performance in meeting Federal and State regulatory requirements and complying with professional standards for services.

   Inherent in these responsibilities is the States' obligations to:

   i. attend to the satisfaction of service recipients, families, and friends with the service system and

   ii. ensure that service providers and support coordination agencies design and implement accountable and responsive internal quality assurance processes.

   The State Medicaid agency is ultimately responsible for administration of the waiver, including oversight of the performance of waiver functions by

other State and local or regional non-State agencies and contracted entities. State government administrators should ensure that their own quality assurance auditing activities provide a reliable and valid evaluation of the performance of its Community-Based Service System consistent with Federal and State regulatory requirements and professional standards. These State-directed quality assurance auditing activities also provide a validation check for providers' internal quality assurance audit processes.

State-directed quality assurance activities typically include:

i. initial and recurring licensing or certification evaluations of providers;

ii. service recipient satisfaction surveys;

iii. critical incident monitoring and investigations;

iv. mortality reviews;

v. overall assessments of the adequacy, accessibility, and nondiscrimination of the service provider and support coordination agency networks; and

vi. certain administrative audits to ensure that the Community-Based Service System is compliant with State and Federal programmatic and fiscal requirements.

State-directed quality assurance audits and assessments also include assurance related to fundamental principles and values of community-based services waiver programs, including nondiscrimination, community inclusion, individualization of service planning, respect for the rights of individuals with disabilities to make their own decisions, and risk management. These assessments are often incorporated in ongoing, person-centered service assessments and service providers' and support coordinators' service delivery, consistent with the requirements of the State's approved waiver.

In addition, State quality assurance activities should include the capacity to identify and respond to trends in providers' internal quality assurance audits, as well as its own State-directed audits. Responding to these trends allows States to ensure timely corrective actions and, where necessary, regulatory reforms to respond to weaknesses in the Community-Based Service Systems before problems become more serious.

6. The Federal Government's role in quality assurance for States' Community-Based Service Systems depends substantially on data and reports of the States' own quality assurance activities.

Specifically, the Federal Government first and foremost should ensure that States' quality assurance processes, including mandates for provider-directed internal quality assurance procedures, operate effectively and efficiently to identify concerns and ensure needed remedial actions in response to their observations and conclusions.

Additionally, the Federal Government should have the capacity to undertake independent quality assurance investigations and audits in response to State quality assurance reports, citizen complaints, and concerns that may surface in Medicaid and Medicare data.

The Federal Government also has the unique capacity to identify and respond to trends in the quality assurance data among States and to use these observations to affect ongoing needed quality improvements in the Federal regulatory framework for State Community-Based Service Systems.

III. Basic Operational Tasks of Quality Assurance

A. Quality assurance processes, whether in industry, education, or health care, have eight basic operational tasks:

1. data collection,
2. data analysis,
3. evaluating the effectiveness of the overall systems,
4. determining findings and conclusions,
5. identifying trends that need to be addressed,
6. identifying corrective actions or remedies (as needed),
7. implementing corrective actions or remedies, and
8. evaluating the effectiveness of implemented corrective actions or remedies.

B. Historically, State quality assurance processes for their Community-Based Services System have invested most of their time and resources on Task 1, data collection. Less time and fewer resources have been spent on Task 2, data review and analysis, and still less time on Task 4, determining findings and conclusions.

States may find they need to allocate more resources to Tasks 5 through 8, the identification, implementation, and evaluation of needed corrective actions that are essential to ensuring positive outcomes of their quality assurance efforts.

C. This allocation of resources is inevitable in view of the disproportionate resources required to collect and analyze quality assurance data relative to other tasks. However, it is critical that the model for States' Community-Based Services Systems ensures that States allocate sufficient time and resources to ensuring the success of the State's quality system and addressing any intended corrective action outcomes of these programs. Without this allocation, quality assurance systems may generate impressive "processes" and reports but minimal positive outcomes.

Thus, the model should ensure that, for each component of the quality assurance process, States develop effective and practical action steps that address all eight tasks with sufficient attention to checks and balances on appropriate and effective corrective action outcomes.

IV. Surveillance Capacities

Surveillance capacities refer to a quality assurance program's "action" capabilities to ensure that it is able to collect reliable and valid data related to the quality assessments undertaken.

A. State quality assurance processes rely on a number of different surveillance capacities that can be generally categorized in five types:

1. external reporting by service recipients, peers, families and friends, service providers and support coordinators (voluntary and mandatory), and protection and advocacy entities;

2. desk/paper audits of service planning and service provision documentation;

3. onsite data collection activities, including routine reviews, inspections, and investigations of service locations, service recipients, and allegations of abuse and neglect or other misconduct;

4. reviews of provider and support coordinator reporting related to mandated reporting and service provision; and

5. State-directed systemic reviews of the service system (often done to assess the overall provider network's stability, accessibility, and fiscal integrity of service billing and reimbursement).

B. Specific data collection activities of quality assurance processes related to these surveillance capacities include (among others):

1. service recipient, peer, family, and friend reporting of concerns and complaints (e.g., informal and formal complaint and grievance systems);

2. satisfaction surveys of service recipients and family and friends;

3. mandated reporting of critical incidents, deaths, and abuse and neglect;

4. mandated provider reporting on the status of high-risk service recipients;

5. mandated provider reporting of weather, fire, and other emergency situations; infection control concerns; involvement of law enforcement; disenrollment of service recipients; and others; and

6. desk audits of service provider and support coordinator documentation, including:

   i. person-centered service plans (PCSPs),

   ii. service billings,

   iii. internal quality assurance audit findings, and

   iv. pre-employment screening and training for staff members.

C. Person-centered quality reviews to ensure assessment and documentation of the individual's needs and documentation that substantiates services were rendered in the amount, frequency, duration, and scope required:

1. onsite inspections of community homes and other service provision locations (e.g., day programs and crisis and respite homes) to assess performance compliance with regulatory and professional standards (i.e., initial certification reviews and ongoing licensure reviews);

2. onsite investigations of critical incidents and other allegations or concerns of performance deficiencies;

3. mortality reviews (independent or State directed) including or in addition to trend analysis of unexpected or unanticipated deaths and trend analysis of deaths that were the result of abuse or neglect;

4. onsite evaluations of service providers' and support coordinators' reporting of critical incidents, implemented corrective actions, PCSP development, service delivery, and billings; and

5. meetings with advocates to identify emerging issues and trends in complaints and rights violations in conjunction with a review of the State's own complaint and appeal systems.

Appendix E
Related HHS Reports and Activities

OIG Office of Audit Services Related Reports

Report Title	Report Number	Date Issued
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	August 2017
Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements	A-01-17-00504	August 2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	July 2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	May 2016
Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	September 2015
Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs	OEI-02-08-00170	June 2012

Administration for Community Living Related Activities

Living Well: Model Approaches for Enhancing the Quality, Effectiveness and Monitoring of Home and Community-Based Services for Individuals with Developmental Disabilities	*https://www.grants.gov/web/grants/view-opportunity.html?oppId=292514*

State Protection & Advocacy Systems	*https://www.acl.gov/programs/aging-and-disability-networks/state-protection-advocacy-systems*
State Councils on Developmental Disabilities	*https://www.acl.gov/programs/aging-and-disability-networks/state-councils-developmental-disabilities*
National Network of University Centers for Excellence in Developmental Disabilities Education, Research & Service	*https://www.acl.gov/programs/aging-and-disability-networks/national-network-university*
Self-Advocacy Resource and Technical Assistance Center (SARTAC)	*http://selfadvocacyinfo.org/*

EVV Good Faith Effort Exemption Requests

Section 12006(a) of the 21st Century Cures Act (Cures Act) mandates that states implement electronic visit verification (EVV) for all Medicaid personal care services by January 1, 2019, or otherwise be subject to incremental federal medical assistance percentage (FMAP) reductions. The Cures Act includes a provision that allows states to delay implementation of EVV for up to one year if they can demonstrate they have made a good faith effort to comply and have encountered unavoidable delays.

- Requests for good faith effort exemptions should be submitted between July 1, 2018 – November 30, 2018.
- It is recommended that the state's request include:
  - Actions the state has performed to adopt EVV and meet the requirements at Section 12006(a) of the Cures Act
  - Proposed EVV model (go to: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051618.pdf for more information on EVV models)
  - Unavoidable system delays/barriers (if you have any questions on what may constitute an unavoidable delay or barrier please email EVV@cms.hhs.gov or contact your CMS Regional Office)
  - Description of the state's stakeholder engagement process
- The state may include its request in a letter addressed to Ralph Lollar, Director of the Division of Long-Term Services and Supports, and signed by the State Medicaid Director, or in an email sent from or including the State Medicaid Director. Please send requests to the EVV mailbox at EVV@cms.hhs.gov with the subject line "[State Name] EVV Good Faith Effort Exemption Request." The EVV mailbox will acknowledge receipt of the letter. Only one request per state should be submitted.
- Within 30 days of receipt of the state's request the CMS EVV mailbox will send a letter attached in an email and signed by the Director of the Division of Long-Term Services and Supports confirming that the state's request has been approved. If the state's request is not approvable, CMS will inform the state of the reason(s) the request was not approved and will offer to schedule a conference call with the state. The state will have the opportunity to revise and resubmit its request.

Please be advised that the Cures Act provision on good faith effort exemptions does not provide CMS with authority to delay the FMAP reductions for more than one year. If you have any questions please email EVV@cms.hhs.gov or contact your CMS Regional Office.

Kennedy, Alice

From: Fuoco, Danielle
Sent: Tuesday, January 30, 2018 10:51 AM
To: Tierney-Ward, Megan
Subject: Global Commitment 2017 Annual Report - Due 2/15/18
Attachments: Choices for Care.docx; Traumatic Brain Injury.docx; Choices for Care and TBI.docx

Importance: High

Hello,

Apologies for the late notice - it's time again for the **Global Commitment Annual Report** (2017)! The Annual Report should include 4th quarter updates (10/1/17 – 12/31/17) as well as a cumulative summary of previous quarters in 2017.

Attached you'll find the 2016 Annual Report section for reference. Please update with tracked changes for the 2017 Annual Report (January 1, 2017 – December 31, 2017). **A draft of this section is due on 2/15/18.** Please update with important developments, findings, challenges, and successes from the past year and include 2-5 key updates in the text box provided.

I also attached a couple of the quarterly report sections for TBI, as this will be the first annual report with a TBI section.

Past quarterly and annual reports can be viewed here.

Let me know if you have any questions or concerns. Thank you!

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i. Choices for Care

Key updates:

- Home Delivered Meals as a Choices for Care service.
- Finalized Case Management and Adult Day Standards with new HCBS Rules.
- Launched new Adult Services Division website.

Home Delivered Meals as a Choices for Care Service

The Agency of Human Services (AHS) was requested by the State Legislature within Act 172, Sec. E.308.1, to determine the amount of existing non-federal dollars currently expended by Area Agencies on Aging to provide home-delivered meals to Choices for Care recipients that could be matched with federal Medicaid dollars without adversely affecting other Choices for Care recipients or individuals receiving home-delivered meals who are not in Choices for Care.

In this quarter, DAIL worked closely with Area Agency on Aging stakeholders within the context of the Older American's Act to thoroughly research the legislative request in preparation for the report. The results of the research and final report submitted February 1, 2017 will appear in the next quarterly report (QE0317).

HCBS Federal Regulations

During this reporting period, work continued to finalize revised standards for Case Management and Adult Day Services in accordance with Vermont's Comprehensive Strategy Systemic Assessment. Documents can be found online at http://asd.vermont.gov/special-projects/federal-hcbs. As of December 30, 2016, the State had not yet received requested guidance from CMS on the topic of conflict of interest and how it relates to Vermont's system of case management.

New Adult Services Division Website Launched

A new website was launched in November 2016 for the Adult Services Division. The website creates improved access to information for both consumers and providers. Get Help Now directs people to relevant resources and program applications. In addition, Special Projects and Initiatives clearly directs people to information such as the status of the Vermont HCBS Systemic Assessment and Work Plan. The new website address is http://asd.vermont.gov/.

Choices for Care FFY16 Annual Summary

- October 2015 DAIL submitted its annual legislative report on the Adequacy of the Choices for Care Provider System. Areas of focus included staffing shortages, Moderate Needs funding and lack of adequate housing & residential care options (especially for people with complex needs).

http://asd.vermont.gov/sites/asd/files/documents/Choices_for_Care_Adequacy_Report_2015.pdf

- AHS, together with DAIL, received stakeholder input and finalized the Choices for Care HCBS Regulations systemic report and work plan for submission to CMS.
- HCBS work plan was initiated with stakeholder involvement and included a change in the Case Management and Adult Day Standards.
- A bill was proposed to add home delivered meals as a Choices for Care services. The bill was not approved but instead the legislature requested a report by February 1, 2017 on potential funding for a new service.
- The MFP grant was approved for $8 million, $5 million less than anticipated.
- SFY17 State budget was approved and included the conversion of $1.2 million (gross) in one-time Moderate Needs funding (SFY16) into the base allocation for services. This helped assure continuity of services for Moderate Needs services into the next fiscal year.
- Vermont implemented a 2% rate increase for Choices for Care home-based and Enhanced Residential Care services effective 9/1/2016.
- Approximately $800,000 (gross) was available at the end of SFY16 to "reinvest" back into long-term services and supports. Due to the timing of the state budget process, any reinvestment will be implemented mid-year SFY2017 or the beginning of SFY2018.

i. Traumatic Brain Injury (TBI) Program

Key updates from QE0617:

- TBI program is a new addition to this report – program summary provided.
- No wait list for TBI services.

Program Summary

In 1991, the Department of Disabilities, Aging and Independent Living (DAIL) began the operation of a three-year pilot project offering community-based rehabilitative services for individuals with moderate to severe traumatic brain injury. The goal of this program was to divert people from facility placement and/or return Vermonters with a moderate to severe traumatic brain injury from out-of-state facilities. Prior to the development of this service, people were placed in expensive out of state facilities, often there for years, with little hope of returning to their home communities. The project demonstrated that individuals with a moderate to severe traumatic brain injury participating in the pilot were able to be served appropriately in community-based settings.

Today the Traumatic Brain Injury Program provides rehabilitation and life skills services in community based settings to approximately 90 Vermonters per year with a moderate to severe traumatic brain injury. This is a rehabilitation-based, choice-driven program intended to support people to achieve their optimum independence and help them return to work.

DAIL works closely with the Brain Injury Association of Vermont and a TBI advisory board, assuring Vermont's continued support for people living with a brain injury. For more information go to the Brain Injury Association of Vermont.

As people with long-term support needs are identified through the TBI program , efforts are being made to transition eligible people to the Choices for Care program for continued long-term services and supports. There is currently no wait list for TBI services in Vermont.

i. Choices for Care

Key updates from QE0317:

- CFC operationalized SFY16 Year End Savings Reinvestments.
- HCBS provider self-assessment tool created.
- No wait list for high/highest; provider wait lists for Moderate Needs only.

SFY16 Reinvestments

In February 2017, the Department of Disabilities, Aging and Independent Living (DAIL) received legislative approval to reinvest approximately $800,000 gross in Choices for Care SFY16 year-end savings. DAIL operationalized these reinvestments by authorizing approximately $481,000 in one-time adjustments for Moderate Needs services provided in SFY17, and approximately $321,000 towards a rate increase to Enhanced Residential Care services effective May 1, 2017. Reinvestments were based on elements presented in DAIL's annual "Adequacy of Choices for Care Provider System" report to the legislature and stakeholder feedback. The adequacy report can be found here: http://legislature.vermont.gov/assets/Legislative-Reports/CFC-Adequacy-Report-9.6.16-v3.pdf

HCBS Federal Regulations

During this reporting period, Vermont continued work to finalize an online provider self-assessment survey for implementation in April. The survey will require that Choices for Care case management, adult day and adult family care providers answer specific questions related to their practices and whether they are in line with the new regulations. The same survey will be used to assess the Traumatic Brain Injury and Developmental Services provider systems. Survey results will help Vermont better understand how provider operations align with the new federal rules and what changes are necessary to comply with the new HCBS Rules by March 2019. For more information on the Choices for Care HCBS work plan, go to: http://asd.vermont.gov/special-projects/federal-hcbs.

Wait List

Choices for Care does not have a wait list for people applying for High/Highest and are clinically and financially eligible for services.

Moderate Needs Group (MNG) services are not an entitlement and instead are limited by funding which is allocated to providers and managed at the local level. This requires that providers establish a wait list when funds are spent in their region. Currently, home health providers report that approximately 700 people are waiting for help to pay for homemaker services statewide and approximately three people are waiting for help to pay for Adult Day services. Though total funding for MNG services was increased to eliminate the wait list in SFY2015, it is important to

note that eligibly for Moderate Needs is quite broad, which creates an opportunity for a very large number of Vermonters to be eligible. Therefore, it is expected that unless the eligibility criteria is modified, wait lists for the limited Moderate Needs funding will continue for the foreseeable future.

ii. Traumatic Brain Injury (TBI) Program

Key updates from QE0317:

- HCBS provider self-assessment tool created.
- No wait list for TBI services.

HCBS Federal Regulations

As with Choices for Care and DDSD, Vermont continued work to finalize an online provider self-assessment survey for implementation in April. The survey will require that TBI providers answer specific questions related to their practices and whether they are in line with the new regulations. Survey results will help Vermont better understand how provider operations align with the new federal rules and what changes are necessary to comply with the new HCBS Rules by March 2019. For more information on the TBI HCBS work plan, go to: http://asd.vermont.gov/special-projects/federal-hcbs.

Wait List

There is currently no wait list for TBI services in Vermont.

HCBS CQS July 2018 000744

Department of Vermont Health Access

Agency of Human Services

Quarterly and Annual Reports 2006 to Current

Global Commitment to Health Quarterly and Annual Reports by Federal Fiscal Year (FFY) and Calendar/Demonstration Year (CY)

CY 2018

- 1st Quarter 2018 (1/1/18 - 3/31/18)

CY 2017

- 1st Quarter 2017 (1/1/17 - 3/31/17)
- 2nd Quarter 2017 (4/1/17 - 6/30/17)
- 3rd Quarter 2017 (7/1/17 - 9/30/17)
- Annual Report (includes Q4 updates; 1/1/17 - 12/31/17)

CY 2016

- 1st Quarter 2016 (1/1/16 - 3/31/16)
- 2nd Quarter 2016 (4/1/16 - 6/30/16)
- 3rd Quarter 2016 (7/1/16 - 9/30/16)
- Annual Report (includes Q4 updates; 1/1/16 - 12/31/16)

FFY 2016

- 1st Quarter 2016 (10/1/15 - 12/31/15)

FFY 2015

- 1st Quarter 2015
- 2nd Quarter 2015
- 3rd Quarter 2015
- 4th Quarter 2015
- Annual Report

FFY 2014

- 4th Quarter 2014

- 3rd Quarter 2014
- 2nd Quarter 2014

- 1st Quarter 2014
- Annual Report

FFY 2013

- 4th Quarter 2013

- 3rd Quarter 2013

- 2nd Quarter 2013

- 1st Quarter 2013
- Annual Report

FFY 2012

- 4th Quarter 2012
- 3rd Quarter 2012
- 2nd Quarter 2012
- 1st Quarter 2012
- Annual Report

FFY 2011

- 4th Quarter 2011
- 3rd Quarter 2011
- 2nd Quarter 2011
- 1st Quarter 2011
- Annual Report

FFY 2010

- 4th Quarter 2010
- 3rd Quarter 2010
- 2nd Quarter 2010
- 1st Quarter 2010
- Annual Report

FFY 2009

- 4th Quarter 2009
- 3rd Quarter 2009
- 2nd Quarter 2009

- 1st Quarter 2009
- Annual Report

FFY 2008

- 4th Quarter 2008
- 3rd Quarter 2008
- 2nd Quarter 2008
- 1st Quarter 2008
- Annual Report

FFY 2007

- 4th Quarter 2007
- 3rd Quarter 2007
- 2nd Quarter 2007
- 1st Quarter 2007
- Annual Report

FFY 2006

- 4th Quarter 2006
- 3rd Quarter 2006
- 2nd Quarter 2006
- 1st Quarter 2006
- Annual Report

A Vermont Government Website

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Vermont Designated Home Health Agencies

- Addison County Home Health and Hospice (Middlebury)
  Call 1-800-639-1521
  Online at http://www.achhh.org/

- Bayada Home Health Care (Statewide)
  Call (802) 857-5030 or 1-888-990-8947
  Online at http://www.bayada.com/

- Caledonia Home Health Care (St. Johnsbury)
  Call 1-800-499-9405
  Online at http://www.nchcvt.org/services/home-carehospice/

- Central Vermont Home Health and Hospice (Barre)
  Call (802) 223-1878
  Online at http://www.cvhhh.org/

- Franklin County Home Health and Hospice (St. Albans)
  Call (802) 527-7531
  Online at http://www.fchha.org/

- Lamoille County Home Health and Hospice (Morrisville)
  Call (802) 888-4651
  Online at http://www.lhha.org/

- Manchester Health Services (Manchester Center)
  Call (802) 362-2126
  Online at http://www.manchesterhealthservices.com/

- Orleans/Essex VNA and Hospice (Newport)
  Call (802) 334-5213
  Online at http://www.orleansessexvna.org/

- Rutland Area VNA and Hospice (Rutland, Bennington, Dorset)
  Call 1-800-244-0568
  Online at http://www.ravnah.org/

- VNA and Hospice of Vermont and New Hampshire (Bellows Falls)
  Call 1-888-300-8853
  Online at http://www.vnhcare.org/

- VNA of Chittenden/Grand Isle (Colchester)
  Call (802) 658-1900
  Online at http://www.vnacares.org/

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VERMONT

Overview

The Centers for Medicare and Medicaid Services (CMS) is responsible for making rules about Medicaid services. In 2014, CMS made new rules that help people who get Medicaid services. The new CMS rules protect your choice about where services are received. The new CMS rules also make sure that services:

- Are integrated in and give full access to the community, which is known as "Community Integration";
- Provide rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Support individual decisions;
- Let you choose what services you need; and
- Who provides the services to you.

The new CMS rules also require that you must have a written agreement if you live in a provider-run residential setting. This agreement must protect your rights in the same way it does for other renters and program participants. Before your rights can be modified, a needs assessment must be completed. You must be asked to agree to the needs assessment. The changes must also be justified in your individualized plan or support agreement.

You have been randomly selected to give us your opinion about the place where you currently live. Your participation for this survey is voluntary. Your opinions are very important. We hope you will choose to answer the survey. Your answers will help us understand how well your provider meets the new CMS rules.

Questions are organized into the following sections:

1. Information about you and where you receive services;
2. Physical characteristics about where you live;
3. Integration with the community;
4. Privacy, dignity and respect;
5. Individual control, decision-making and independence;
6. Your rights with respect to where you live.

Instructions for Interviewer

Most of the questions are to be asked of the member and/or member's representative. A small portion are to be answered by the assessor based on his/her observation of the setting. These questions are flagged as, "To be completed by Interviewer".

The survey is designed to return yes/no answers to each question. If the individual responding to questions struggles to understand the question, examples or prompts to help clarify the question are included for **many of the questions. To ensure that all consumers are answering the same question, please try to use** first question as listed in the interview before moving on to additional prompts or examples. If the individual does not appear to understand the question after additional prompts or provides conflicting detail for the same question mark the response as "D/K".

This survey is designed for multiple types of residential settings, you will need to customize the **terminology based on the person and type of setting you are visiting. For example in some cases, "housemate" may be more appropriate than "roommate"; "home" may be more appropriate than "room". In some cases, the provider may be a residential care or group home name "The Pines" and in other cases a** family care home "The Smith's"; please use whatever name is most familiar to the person being interviewed. As you refer the "the provider" throughout the questions, please note that:

- Each question allows you to add a comments or observations. You are not required to add comments; however, if you feel that there are items needed for follow-up or requiring clarification that is important to the results, please use the comment box to add that information.
- The first section of the survey requires you fill out demographic information about the consumer, provider and location. DAIL will provide this information to you for each person and/or the provider staff assigned to work with you. Please make sure that you have the necessary details to fill out the demographic information in order to complete the survey.

Questions regarding the assessment should be directed to:

Agency of Human Services:
Shawn Skaflestad, Quality Improvement Manager
(802) 241-0961
Shawn.skaflestad@vermont.gov

Developmental Disabilities Services Division:
Chris O'Neill, DAIL- DDSD Quality Management Team Leader
(802) 241-0332
Chris.ONeil@vermont.gov

Adult Services Division:
Quality & Provider Relations Director (802) 786-2516
Andre.Courcelle@vermont.gov

Section 1- DEMOGRAPHIC INFORMATION

To be completed with information provided by DAIL and/or Provider.

Member's Last Name [redacted]

Member's First Name [redacted]

Who is completing the survey? **Kathy Hamilton - DAIL employee**

Last Name of Person Assisting: _____

First Name of Person Assisting: _____

Relationship to Participant: _____

Date of Enrollment with Provider: **10/7/2015 - TBI program**

Provider Name and Mailing Address (This question is required.)

Provider or Host Agency Name: **Families First**

Provider Contact Name: _____

Street or PO Box: _____

City: _____

State: _____

Zip Code: _____

Program and Setting 'This question is required.

Program (choose one):

- ____Choices for Care Program (choose one setting)
  - ___Adult Day Setting
  - ___Adult Family Care Setting
  - ___Enhanced Residential Care Setting

-OR-

- **X**__ Traumatic Brain Injury Program (Choose one setting)
  - ___Residential Care Home
  - ___Shared Living
  - ___Staffed Living
  - ___Supervised Living

Provider Service Location (This question is required.)

Location Name: _____

Street or PO Box: **1098 Wilmington Crossroads**

City: **Whitingham**

State: **VT**

Zip Code: **05361**

Interviewer Completing Self-Assessment *This question is required .

Last Name: **Hamilton**

First Name: **Kathy**

Office Telephone: **802-442-9191**

Email: **kathleen.hamilton@vermont.gov**

2 - PHYSICAL LOCATION CHARACTERISTICS

This section is to be completed entirely through Interviewer observation.

All questions are required unless noted otherwise.

2.1 Is the residence/service setting located In a building that is also a publicly or privately operated facility that provides Inpatient institutional treatment (NF, IMO, ICF/1Dor hospital)?

___Yes
___No

Comments:

2.2 Is the residence/service setting located in a building on the grounds of, or Immediately adjacent to, a public institution (e.g. prison or State-operated hospital)?

___Yes
___No

Comments:

2.3 Is the residence/service setting one of multiple locations that the provider owns or operates on the same street? (Answer "no" if the residence/service setting is a duplex or multiplex and there are no others owned or operated by the provider on the street.)

___Yes
___No

Comments:

2.4 Is the residence/service setting located in a gated/secured community for persons with disabilities?

___Yes
___No

Comments:

2.5 Is the residence/service setting located in a farmstead or disability-specific community?

___Yes
___No

Comments:

2.6 Is the residence/service setting designed specifically for persons with disabilities? (Please note for community based home settings developed specifically and uniquely for one or two residents based on their needs and preferences, please check "No")

___Yes
___No

Comments:

2.7 Are the individuals who reside/receive services in the setting primarily people with disabilities? (Please note for community-based home settings developed specifically and uniquely for one or two residents based on their needs and preferences, please check "No")

___Yes
___No

Comments:

2.8 Is the service setting located in the same building as an educational program or school?

___Yes
___No

Comments:

2.9 Is the setting located among other residential buildings, private businesses, retail businesses, restaurants, doctors' offices etc., so as to facilitate integration with the greater community? (For rural communities if the setting is commensurate with other locations seen in community or neighborhood, please respond "yes")

___Yes
___No

Comments:

2.10 Notwithstanding DAIL approved security measures, is the setting free from gates, Velcro strips, locked doors and other barriers preventing residents from entering or exiting certain areas of the setting?

___Yes
___No

Comments:

2.11 Are supports, such as grab bars, wheelchair ramps, bathroom seats and viable emergency exits, provided for individuals who need supports to move about the setting as they choose?

___Yes
___No

Comments:

2.12 Are tables and chairs at a convenient height and location so that individuals can access and use them comfortably?

___Yes
___No

Comments:

2.13 Does the physical environment support a variety of individual goals and needs (e.g., does the setting provide indoor and outdoor gathering spaces; does the setting provide for larger group activities as well as solitary activities; does the setting provide for stimulating as well as calming activities)?

___Yes
___No

Comments:

2.14 Does the dining area afford dignity to diners, including by not requiring individuals to wear bibs and by not using disposable cutlery, plates and cups?

___Yes
___No

Comments:

2.15 Does the setting post in a prominent location or otherwise furnish information on the provider's policies concerning individual rights?

___Yes
___No

Comments:

HCBs CQS July 2018 000758

Section 3- INTEGRATION WITH THE COMMUNITY

All questions are required unless noted otherwise.

Instructions to be Read to Member

I am here on behalf of the State because we're interested in learning about your experience at -PROVIDER NAME-. We especially want to make certain that you are. treated with respect and have the same rights and freedom as other people who live elsewhere in this community.

I am going to ask questions that you can answer yes or no. You can explain your answer if you want to share more Information. It should take about 30 minutes. *(Note to assessor:* Members *also can answer "Don't Know" but should not be prompted with this option.)*

What you tell me will be kept confidential and will not be shared with **-PROVIDER NAME-.** We will combine your answers with the answers of other people around Vermont.

Nothing you tell me will affect your eligibility for services. The information will only be used to improve services for people like you around the State.

Do you have any questions before we begin? If not, is it OK to start?

First, I have some questions about whether you have opportunities to do things In the community and here at -PROVIDER NAME-.

3. 1 If you want to, can you go out into the community during the day? (Interviewer prompt: "For example, are you able to visit friends, go shopping or to a movie?")

___ Yes
___ No
___Don't Know

Comments:

3.2 Does -**PROVIDER NAME-** tell you about things to do, like shopping, attending church, eating out or going to concerts, parades, movies or fairs?

___ Yes
___ No
___Don't Know

Comments:

3.3 In the past month, have you gone shopping, to church or out to eat with family and friends? *(This does* not *include going to a job.)*

___ Yes
___ No
___Don't Know

Comments:

3.4 Have you been given information about available transportation? *(Interviewer prompt: For example, has* anyone *shown you how* to use the *bus or call a taxi)*

___ Yes
___ No
___Don't Know

Comments:

3.5(If member uses a wheelchair, ask. Otherwise enter NIA): Have you been given information about wheelchair accessible transportation?

___ Yes
___ No
___Don't Know
___N/A

Comments:

3.6 If you want to, can you have a paid job? *(Interviewer prompt: For example,* is *there someone* to *help you look for or* get *ready for job, if you want one?)*

___ Yes
___ No
___Don't Know

Comments:

3.7 Have you told **·PROVIDER NAME-** that you wanted a job?

___ Yes
___ No
___Don't Know

Comments:

3.8 Do you have a paid job?

___ Yes
___ No
___Don't Know

Comments:

3.9 If you want to, can you volunteer in the community? *(Interiewer Prompt: For example, is there someone to help you look for volunteer work, if you asked?)*

___ Yes
___ No
___Don't Know

Comments:

3.10 Have you told **-PROVIDER NAME-** that you wanted to volunteer somewhere?

___ Yes
___ No
___Don't Know

Comments:

3.11 Are you volunteering somewhere?

___ Yes
___ No
___Don't Know

Comments:

3.12 Can you go anywhere you want inside and outside this house?

___ Yes
___ No
___Don't Know

Comments:

3.13 Can people come and visit you anytime?

___ Yes
___ No
___Don't Know

Comments:

3.14 Are you allowed to have guests stay overnight?

___ Yes
___ No
___Don't Know

Comments:

3.15 Do you have access to your money? *(Interviewer prompt: For example, can you buy things you need and make choices about how to spend your money?)*

___ Yes
___ No
___Don't Know

Comments:

3.16 Were you offered help setting up a savings or checking account that you control? *(Interviewer prompt: For example,* has *anyone* ever *helped you open a bank account?)*

___ Yes
___ No
___Don't Know

Comments:

3.17 Do you have a savings or checking account that you control? *(Interviewer prompt: For example, does anyone else have to sign your bank slips?)*

___ Yes
___ No
___Don't Know

Comments:

3.18 Do you have a choice in what services and supports you receive? *(Interviewer Prompt: For example, if you wanted* more *time* out *of the house or wanted to talk to a* counselor, *can* you *ask* for *that support?)*

___ Yes
___ No
___Don't Know

Comments:

3.19 Do you have a choice in who provides your services and supports? *(Interviewer Prompt: For example, if you wanted a different helper or wanted another place* to *live, do people* listen *to you?)*

___ Yes
___ No
___Don't Know

Comments:

Section 4- PRIVACY, DIGNITY & RESPECT

All questions are required unless noted otherwise.

Interviewer Prompt: "Next, I have some questions about how you're treated here at **-PROVIDER NAME-** and whether your privacy Is respected."

4.1 Can you be alone if you want to be during the day? *(Interviewer prompt: For example, can you* have *a conversation* with *a friend in private? Do* you *have time without staff listening or watching?)*

___ Yes
___ No
___Don't Know

Comments:

4.2 Do the staff members who support you while you are working or participating in an activity treat you the way you want to be treated? */Interviewer prompt: For example, do helpers and staff listen to you?)*

___ Yes
___ No
___Don't Know

Comments:

4.3 Do you need help getting dressed?

___ Yes
___ No
___Don't Know

Comments:

4.4 Do you pick out your *own* clothes?

___ Yes
___ No
___Don't Know

Comments:

4.5 Does -**PROVIDER NAME**- give you a safe place to store your personal belongings? *(Interviewer Prompt: Do you have a Sate pflace to keep* your *stuff at home?)*

___ Yes
___ No
___Don't Know

Comments:

- ○ Yes
- ○ No
- ○ D/K

Comment:

Meeting 10/25/17

Megan Tierney-Ward, Andre Courcelle, Stuart Senghas, Sara Lane, Angela McMann

Andre:

- Contact Shawn for most recent provider self-assessment survey list and update excel sheet by Friday 3rd
- Identify providers who need a call. Depending on counts, delegate to quality staff and call each provider to get the correct contact person. Send link to correct contact person with instructions by Nov 10th
- Get final consumer validation survey tool from Shawn and determine if it is also entered online.

Megan:

- Reach out to Clare to find out if their validation was completed by Kathy Hamilton and what contract was used to pay for the work.
- Pull the new 15% counts and email Dale for sampling method by November 10th.
- Set up meeting for 3 weeks.

Kennedy, Alice

From: Hill, Bard
Sent: Tuesday, October 04, 2016 11:43 AM
To: Tierney-Ward, Megan; Courcelle, Andre; Gerstenberger, Roy; McFadden, Clare; Carmichael, Erin; Skaflestad, Shawn; mbailit@bailit-health.com
Subject: FW: SOTA Update October 04, 2016: New Tool Available To Help Improve Person-Centeredness Of Home And Community Based Services

New Tool Available To Help Improve Person-Centeredness Of Home And Community Based Services

CMS recently released the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Home- and Community-Based Services Survey. The survey makes it possible for home- and community-based services (HCBS) programs to gauge the experiences of beneficiaries with the aspects of these services that matter the most to them.

Development and testing of the HCBS CAHPS Survey was funded by CMS starting in 2009, and is the first CAHPS survey which addresses the needs of individuals accessing HCBS services. CAHPS surveys focus on aspects of quality which are best addressed by individuals receiving care, and ask individuals to report on and evaluate their experiences of care. The CAHPS program, which is funded by the U.S. Agency for Healthcare Research and Quality, supports the use of the HCBS CAHPS Survey. CMS has been a major partner in the CAHPS program since 1996.

The HCBS CAHPS Survey facilitates comparisons across the hundreds of state Medicaid HCBS programs throughout the country that target different adults with disabilities; including frail elderly, individuals with physical disabilities, persons with developmental or intellectual disabilities, those with acquired brain injury and persons with severe mental illness. These individuals total more than 3 million; HCBS users account for two-thirds of Medicaid LTSS beneficiaries and over 50 percent of their spending.

The new tool is available for voluntary use in HCBS programs, including both fee-for-service programs as well as managed LTSS programs, as part of quality assurance and improvement activities. Aspects of LTSS covered by the HCBS CAHPS Survey are staff reliability, communication with staff, getting help from case managers, choice of services, personal safety, adequacy of medical transportation, and community inclusion and empowerment.

For more information on the HCBS CAHPS Survey, please visit https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/cahps-home-and-community-based-services-survey.html

The call dial in/webinar information is listed below:
Thursday October 6, 2016 at 1:30 pm to 2:30 pm ET
Audio option #1: 1-877-267-1577 Participant Code: 991 969 000

Audio option #2 and webinar link:
https://meetings.cms.gov/orion/joinmeeting.do?MTID=f11c741f504abbab343e9f9df8da0791&RT=MiM3

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Wednesday, December 20, 2017 10:38 AM
To: Tierney-Ward, Megan
Subject: one care

MFP care transitions
HCBS regulations
Motivational interviewing and training opportunities

Get Sara Barry's email from Liz.

Megan

Megan Tierney-Ward
Adult Services Division Director

November is National Family Caregiver Month. ***Over 64,000 Vermonters are family caregivers****, providing countless hours of unpaid but essential care to loved ones young and old. Find out more about what it's like to be Caregiving Around the Clock. If you are a caregiver of an older Vermonter, contact the Senior Helpline at* ***1-800-642-5119*** *to learn more about family caregiver training, counseling, peer support, and respite options in your community, and check out these 10 Tips for Family Caregivers.*

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. Thank you.

2/6/18

1. Sample Size approximation:
    a. AFC = 14
    b. TBI = 12

2. Pilot 2 people:
    a. AFC = UCS - Bennington
    b. TBI = Families First - Whitingham

3. DAIL will create a workable paper version of the survey for Kathy and send 5 copies to Kathy at:
    224 Bradley Drive
    Bennington VT 05201

4. Any questions about the survey questions can be directed to Andre. Megan has requested an ASD task profile code be added to Kathy's ERP time card.

5. Process:
    a. DAIL emails Kathy:
        i. name of clients,
        ii. copy of provider self-assessment, and
        iii. provider contact name and number.
    b. Andre sends an email to applicable providers to let them know the validation survey will happen, starting with the two pilot agencies. Copy Kathy in the heads-up email.
    c. Kathy contacts the provider for some information about the consumer, arranges the visit and completes the survey.
    d. After surveys complete, answers are entered in the survey database: Discuss with Andre who should enter the survey into the database. Someone at ASD or Kathy.
    e. Andre monitors the data and provides technical assistance.
    f. Once pilot done, review the pilot experience and make changes accordingly.
    g. DAIL sends rest of AFC and TBI survey sample, provider contacts, provider self-assessment, and blank surveys to Kathy.
    h. Surveys must be completed by 9/30/18. Verify with Andre.

6. ASD is also doing validation surveys for Adult Day. Depending on the timeframe, Andre will discuss potential for Kathy's assistance with some Adult Day surveys.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Dear Governor:

We write to you to affirm our partnership in improving Medicaid and the lives of those it serves. Medicaid is a safety net program that provides life-saving medical care to millions of Americans facing some of the most challenging health circumstances. In addressing the diversity and complexity of Medicaid recipients, we have a duty to ensure the highest level of quality, accessibility, and choices for Americans who rely on the program. We also have an obligation to taxpayers to make sure Medicaid operates in a way that best serves the most vulnerable populations.

Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable.

Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid's challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.

As we break down the barriers to support state initiatives aimed at continuously improving the health outcomes for their Medicaid population, we remain committed to certain mechanisms, which ensure state accountability for the outcomes produced by the Medicaid program. For example, budget neutrality for waivers and demonstration projects remains an important policy for protecting the long-term sustainability of the program for states and the federal government,

and state waiver and demonstration requests will continue to be reviewed on a case-by-case basis. Similarly, reasonable public input processes and transparency guidelines provide states an opportunity to consider the views of Medicaid enrollees and stakeholders and gather input that may support continuous improvement of the program.

Some of the key areas where we will improve collaboration with states and move towards more effective program management are described below.

Improve Federal and State Program Management
The Centers for Medicare & Medicaid Services (CMS) is committed to engaging with states in a bilateral process to make the State Plan Amendment approval process more transparent, efficient, and less burdensome. Additionally, we aim to improve the process and speed to facilitate expedited—or "fast-track"—approval of waiver and demonstration project extensions. We also endeavor to be more consistent in evaluating and incorporating state requests for specific waivers and demonstration project approaches that have already received approval in another state. Finally, we plan to conduct a full review of managed care regulations in order to prioritize beneficiary outcomes and state priorities.

Support Innovative Approaches to Increase Employment and Community Engagement
Today, we reaffirm the agency's commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.

Align Medicaid and Private Insurance Policies for Non-Disabled Adults
States may also consider creating greater alignment between Medicaid's design and benefit structure with common features of commercial health insurance, to help working age, non-pregnant, non-disabled adults prepare for private coverage. These state-led reforms could include, as allowed by law:

- Alternative benefit plan designs and cost-sharing models, including consumer-directed health care with Health Savings Account-like features, for individuals at all income levels;
- Facilitating enrollment in affordable employer-sponsored health insurance options;
- Reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations;
- Initiatives designed to break down the barriers that prevent families from being together on the same plan;
- Waivers of non-emergency transportation benefit requirements;
- Expanded options to design emergency room copayments to encourage the use of primary and other non-emergency providers for non-emergency medical care; and
- Waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage.

Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation

CMS has worked with our state partners and other stakeholders to implement provisions of the final regulation defining a home and community-based setting. In recognition of the significance of the reform efforts underway, CMS will work toward providing additional time for states to comply with the January 16, 2014, Home and Community-Based Services (HCBS) rule. Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings.

Provide States with More Tools to Address the Opioid Epidemic

We are committed to ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities. In recognition of the urgent need to improve access to comprehensive substance abuse treatment, we will continue to work with states to improve care for individuals struggling with addiction under their Medicaid state plans and through the Medicaid Innovation Accelerator Program to improve their substance abuse treatment delivery systems. In addition, under recent regulatory changes, states may now make managed care capitation payments for individuals with Institutions for Mental Disease stays of 15 days or less within a month. We will continue to explore additional opportunities for states to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities. We look forward to building upon initial efforts, including previous collaborations amongst the states.

We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our shared goals of providing high quality, sustainable, health care to those who need it most.

Yours truly,

Thomas E. Price, M.D.
Secretary

Seema Verma, MPH
CMS Administrator

Choices for Care provider message for the following providers:

- Adult Day Providers = Adult Day Services
- Area Agencies on Aging = CFC Case Management
- Home Health Agencies = CFC Case Management
- Authorized Agencies = CFC Adult Family Care

Hello,

As a valued member of our Choices for Care (CFC) provider community, we are requesting that you participate in an important survey. Your responses will help us better understand how your current operations align with the new federal rules from CMS on services funded through Home & Community Based Services Medicaid (HCBS), and how we can work together to make any necessary changes.

Even though you may be a provider of more than one HCBS program, this survey pertains specifically to the work you do as a Choices for Care provider. ***Please complete the survey by Friday, April 28th.***

If you are an Area Agency on Aging or Home Health Agency provider of CFC Case Management, please note that in the Provider Information section, you will leave the "setting" questions blank, skip the sections 2.-6. about settings and complete section 7. Personal-Centered Planning Process.

For more information about the HCBS federal rules, go to https://hcbsadvocacy.org/learn-about-the-new-rules/. For information on the Choices for Care work plan, go to http://asd.vermont.gov/special-projects/federal-hcbs. For questions about this survey, please contact Andre Courcelle at andre.courcelle@vermont.gov.

Thank you so much for your time and feedback.

Sincerely,

Megan Tierney-Ward, Director
Adult Services Division
Vermont Department of Disabilities, Aging & Independent Living

TBI Program provider message:

Hello,

As a valued member of our Traumatic Brain Injury provider community, we are requesting that you participate in an important survey. Your responses will help us better understand how your current operations align with the new rules from CMS on services funded through Home & Community Based Services Medicaid, and how we can work together to make any necessary changes.

Even though you may be a provider of more than one HCBS program, this survey pertains specifically to the work you do as a TBI Program provider. ***Please complete the survey by Friday, April 28th.***

For more information about the HCBS federal rules, go to https://hcbsadvocacy.org/learn-about-the-new-rules/. For information on the TBI Program work plan, go to http://asd.vermont.gov/special-projects/federal-hcbs. For questions about this survey, please contact Andre Courcelle at andre.courcelle@vermont.gov.

Thank you so much for your time and feedback.

Megan Tierney-Ward, Director
Adult Services Division
Vermont Department of Disabilities, Aging & Independent Living

Kennedy, Alice

From: Brooks, Dale
Sent: Wednesday, October 25, 2017 3:51 PM
To: Tierney-Ward, Megan
Subject: Re: random sample

Yes, Megan. I can help with that.

Get Outlook for iOS

From: Tierney-Ward, Megan
Sent: Wednesday, October 25, 2017 3:48:34 PM
To: Brooks, Dale
Subject: random sample

Hi Dale,
We are about to do a consume survey for our HCBS regulations validation process. It requires that we pick a 15% random sample of consumers receiving certain CFC and TBI services. Do you have an "easy" way to pick a random sample from a list of names?

M

Megan Tierney-Ward
Adult Services Division Director

Falls are the leading cause of fatal and non-fatal injuries among older adults, but you have the power to prevent a fall. September is ***Falls Prevention Awareness Month***! Learn more at Falls Free Vermont or by calling the Senior Helpline at 1-800-642-5119.

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov*. Thank you.*

Kennedy, Alice

From: Krueger, Maura
Sent: Thursday, September 28, 2017 1:23 PM
To: Tierney-Ward, Megan; Bedard, Colleen; Woods, Mary; Brown, Paula; Senghas, Stuart; Kenworthy, Kathleen
Subject: RE: [secure] RE: URGENT IRATE CALLER

Follow-up: I returned a call to Brenda Donley from GMSS this morning. She has a call in to [redacted] and has additional training planned. She said that the "behavior plan" referred to by the home provider was never a part of the client's care plan. In fact she said it seems "almost punitive to me" in nature, and listed "consequences" for behaviors, which are never a part of *any* client's person-centered plan. She felt that [redacted] likely felt frustrated when the case manager explained that this "plan" would not be used. She reported that this client has not required the use of a crisis home in what she referred to as a very long time. She believes the home provider wrote up the plan in the past. Brenda Donley will write a follow-up note in SAMS on this... so I do not plan to.

Maura L. Krueger, RN, LTCCC
Choices for Care Program
63 Professional Drive, Suite 4
Morrisville, VT 05661
Office: (802) 888 – 0510
Direct Fax: (802) 888 – 0536

**My email address has changed to: maura.krueger@vermont.gov

From: Tierney-Ward, Megan
Sent: Wednesday, September 27, 2017 1:09 PM
To: Krueger, Maura <maura.krueger@vermont.gov>; Bedard, Colleen <Colleen.Bedard@vermont.gov>; Woods, Mary <Mary.Woods@vermont.gov>; Brown, Paula <paula.brown@vermont.gov>; Senghas, Stuart <Stuart.Senghas@vermont.gov>; Kenworthy, Kathleen <Kathleen.Kenworthy@vermont.gov>
Subject: RE: [secure] RE: URGENT IRATE CALLER

Perfect Maura! The best solution is for her to work it out with GMSS.

I'm copying Stuart Senghas because he works with the HCBS rules standards and also copying Katie since she's been working with AFC providers. It is a learning curve for everyone involved.

I see two possible scenarios: GMSS could no longer justify the behavioral plan restrictions within the new HCBS regulations guidelines and have adjusted the plan accordingly... or they have mis-interpreting the HCBS rules with regards to "modifications" and how to manage them.

Stuart and/or Katie, feel free to follow up with GMSS in case they need TA with regards to the HCBS regulations and modifications.

Megan

From: Krueger, Maura
Sent: Wednesday, September 27, 2017 11:54 AM
To: Bedard, Colleen <Colleen.Bedard@vermont.gov>; Woods, Mary <Mary.Woods@vermont.gov>; Brown, Paula <paula.brown@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: [secure] RE: URGENT IRATE CALLER

Hi Folks,

Received a call from [redacted]TBI – very difficult to place, significant behavior issues over the years. Has been in [redacted]home for many years. She was initially a live-in care provider w/HB plan, then transitioned to become an AFC Home in 2015. [I believe there have been CIR's in the past on this client but I am unaware of details.] Client has had to utilize a "Crisis Home" through GMSS.

According to [redacted] there is a behavior plan in place which seems to work in the AFC Home, except during these "crisis" periods. [redacted] reports that [redacted]oticed that when the client returned from the crisis home, it was a challenge to transition back to the behavior plan. So for consistency, they developed a plan to be followed when the client goes to the Crisis Home (according to her) so that the client would know the same behavior limits as in the AFC Home. [I have never seen this plan – unclear if it is a plan she wrote-up herself or if it is part of the client's plan.]

According to [redacted] she was told by GMSS that this behavior plan they had for use in the "crisis home" could no longer be used "because they told me it's not person-centered". She also mentioned something about Medication Sheets, but she was not specific.

Initially she asked me about CFC Regulations. I explained that each program has Regs. Also explained that each Provider Agency has Policies and Procedures specific to their agency based on those Regs. I offered that we ask each Authorized Agency to review their process, making changes to improve care. She seemed frustrated with the "Person-Centered" terminology, in reference to this "plan" previously in place to follow in the "Crisis Home". I explained that all of our programs are charged to ensure that each person's care is specific to their needs. I also explained that my role is initial assessment, and authorization of annual service plans. Periodically during the conversation I redirected her to the case manager at the AA.

RECOMMENDATION: I suggested that [redacted]call GMSS and ask for a meeting with [redacted]Case Manager so that they can discuss her frustrations. She seemed very calm after we finished talking on the phone, and felt that was a good idea.

Is there anything else I need to do with this other than a Journal Note?

Maura L. Krueger, RN, LTCCC
Choices for Care Program
63 Professional Drive, Suite 4
Morrisville, VT 05661
Office: (802) 888 – 0510
Direct Fax: (802) 888 – 0536

**My email address has changed to: maura.krueger@vermont.gov

From: Bedard, Colleen
Sent: Wednesday, September 27, 2017 11:09 AM
To: Krueger, Maura <maura.krueger@vermont.gov>
Subject: RE: URGENT IRATE CALLER

[redacted]

Colleen Bedard
Administrative Services Coordinator III
DAIL/Adult Services Division
Phone: MON. TUES. WED. 802-241-0294 THURS. FRI. 802-760-8372
Fax: 802-241-0385

From: Krueger, Maura
Sent: Wednesday, September 27, 2017 11:05 AM
To: Bedard, Colleen <Colleen.Bedard@vermont.gov>
Cc: Brown, Paula <paula.brown@vermont.gov>; Woods, Mary <Mary.Woods@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: URGENT IRATE CALLER

I am on the phone with her now

Maura L. Krueger, RN, LTCCC
Choices for Care Program
63 Professional Drive, Suite 4
Morrisville, VT 05661
Office: (802) 888 – 0510
Direct Fax: (802) 888 – 0536

**My email address has changed to: maura.krueger@vermont.gov

From: Bedard, Colleen
Sent: Wednesday, September 27, 2017 11:04 AM
To: Krueger, Maura <maura.krueger@vermont.gov>
Cc: Brown, Paula <paula.brown@vermont.gov>; Woods, Mary <Mary.Woods@vermont.gov>; Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: URGENT IRATE CALLER
Importance: High

Hello,
I just received a call from a [redacted] re: [redacted] She was screaming about a change in state regulations, person centered changes, a change in sheets for drugs etc. I had no idea what she was talking about so I told her I would have to have one of the supervisors call her back after their meeting. She said "is that Megan Tierney-Ward?" I said "no, Megan is the director." She said "well your website says to call Megain Tierney-Ward. You should change that to say to contact Mary Woods or Paula Brown." I said "no, she's not the first person you would need to talk to." She started arguing with me so I asked her who she worked for. She said she works for the State of Vermont for the Agency of Human Services. She asked my name and I told her Colleen Bedard. So she will probably make a complaint about me. When I pulled up the client, it says he is on AFC Tier 10 under Green Mountain Support Services. She would like someone to call her back STAT at 635-7959.

Colleen Bedard
Administrative Services Coordinator III
DAIL/Adult Services Division
Phone: MON. TUES. WED. 802-241-0294 THURS. FRI. 802-760-8372
Fax: 802-241-0385

Kennedy, Alice

From: Senghas, Stuart
Sent: Thursday, February 15, 2018 5:18 PM
To: Tierney-Ward, Megan
Subject: Re: CMS ?

Got it!!

Sent from my iPhone

On Feb 15, 2018, at 4:10 PM, Tierney-Ward, Megan <megan.tierney-ward@vermont.gov> wrote:

> They fall under Home & Community-Based Services (HCBS). That is why they were included in our state's assessment of compliance with the federal HCBS regulations.
>
> ---
>
> **From:** Senghas, Stuart
> **Sent:** Thursday, February 15, 2018 3:56 PM
> **To:** Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
> **Subject:** CMS ?
>
> Megan,
>
> Do you know of hand how CMS classifies Adult Day programs in Vermont?
> Are Adult Day programs considered a Long Term Care facility or a Nursing Home?
> Do we have a specific category?
>
> Thanks!!
>
> Stuart

Stuart Senghas, MSW
Quality and Program Participant Specialist
Adult Services Division
Department of Disabilities, Aging, & Independent Living
280 State Dr., HC 2 South, Waterbury, VT 05671-2070
Desk: 802-241-0307
Cell: 802-585-5730
Fax: 802-241-0385
Email: stuart.senghas@vermont.gov

<image002.png>

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For information, referral and assistance for adult Vermonters, contact your Aging & Disabilities Resource Connections/No Wrong Door partner:

- Vermont 211: Dial 211

- Senior Helpline: 1-800-642-5119 (for people 60 and older)
- VT Center for Independent Living: 1-800-639-1522 (for people under 60)
- Brain Injury Association of VT: 1-877-856-1772

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Friday, November 17, 2017 1:25 PM
To: Skaflestad, Shawn; Courcelle, Andre
Subject: Re: CMS CQS Response due today

You're welcome!

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 1:15 PM
To: Tierney-Ward, Megan; Courcelle, Andre
Subject: RE: CMS CQS Response due today

Thanks Megan! I will include the language below in today's response:

The state plans to use their existing TBI quality review process to make certain that any use of restrictive interventions will be handled and documented via the person-centered planning process, following the criteria in 42 CFR 441.301(c)(viii)(A) through (H).

Shawn

From: Tierney-Ward, Megan
Sent: Friday, November 17, 2017 12:57 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: Re: CMS CQS Response due today

Like CFC we will incorporate the hcbs "modifications" requirement language into the TBI standards and follow those standards. Assurance will be built into the TBI quality review process, like CFC.

Get Outlook for iOS

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 12:53:05 PM
To: Tierney-Ward, Megan; Courcelle, Andre
Subject: RE: CMS CQS Response due today

As far as today's submission is concerned, I see the following two options:

1. Tell CMS that the work plan has been modified to include *how the state will ensure that any use of restrictive interventions will be handled and documented via the person-centered planning process, following the criteria in 42 CFR 441.301(c)(viii)(A) through (H).*
2. Request a meeting w/CMS so they can clarify their comment.

If we choose #1 – I am not sure what details would be added to the work plan.

Shawn

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 10:17 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>
Subject: CMS CQS Response due today

Hi Megan and Andre,

According to our TBI systemic assessment – Vermont regulations/policies are silent on all of the modifications (A-H) listed under

14. Modification to HCBS Settings Requirements: Restrictions of rights and/or restrictive practices are not contemplated in program guidance (settings requirements)

In our workplan we said we would do a bunch of things to bring our regulations/policies in line with those of the Feds. After looking over the TBI work plan – CMS made the following comment:

> *Please clarify how the state will ensure that any use of restrictive interventions will be handled and documented via the person-centered planning process, following the criteria in 42 CFR 441.301(c)(viii)(A) through (H).*

Any suggestions re: how we might reply to this comment?

Shawn

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Thursday, July 20, 2017 1:20 PM
To: Tierney-Ward, Megan; Courcelle, Andre; Gerstenberger, Roy; Harrigan, Emma; Omland, Laurel; Hill, Bard
Subject: RE: CMS HCBS Milestone Workplan
Attachments: VT Milestone Template July 20, 2017.docx

Thanks for getting together to discuss the milestone template. I am attaching a modified version to this email. Please review and let me know if the dates still make sense across all programs. Keep in mind that you can insert more aggressive dates into your individual timelines.

I look forward to hearing your feedback.

Shawn

-----Original Appointment-----
From: Skaflestad, Shawn
Sent: Monday, June 26, 2017 3:11 PM
To: Tierney-Ward, Megan; Courcelle, Andre; Gerstenberger, Roy; Harrigan, Emma; Omland, Laurel; Hill, Bard
Subject: CMS HCBS Milestone Workplan
When: Monday, July 10, 2017 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: AHS - WSOC Boxelder 10 OR Dial-In Number: 1-877-273-4202 Conference Room ID: 1262904

Hi All,

This is a meeting to discuss the attached Excel spreadsheet. Rather than having one HCBS workplan like CMS has proposed (also attached) – I am suggesting a separate one for each program. Before we meet – please take some time and review the Excel file – paying special attention to the Topic, Milestone, and what is current written in the CQS/STP about the related topic (reference is listed in the CSQ/STP Page No. column). By the end of our meeting – I would like us to agree on the Milestones and what is currently written in the CQS/STP about the topic – as well as suggested due dates for each milestone.

Please note that a dial in option is available for those unable to attend in person.

Thank you,

Shawn

SECTION	TOPIC	MILESTONE	SUB-MILESTONE	DUE DATE
I	**Systemic Assessment and Remediation (2)**	Completion of systemic assessment		Done
		Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.		
			Implementation of new rules and regulations: 50% complete	
			Implementation of new rules and regulations: 100% complete	**3/17/2018**
II	**Site-specific Assessments (e.g., HCBS Survey) (3)**	Completion of site-specific assessment		**9/17/2018**
		Incorporate results of settings analysis into final version of the STP and release for **public comment**		**11/17/2018**
		Submit final STP to CMS		**1/17/2019**
III	**Site-specific Remediation (3)**	Identify remedial action steps (i.e., corrective action plan) for **residential** settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment.		**11/17/2018**
		Can start as soon as 3/17/2019	Completion of residential provider remediation: 25%	**7/17/2021**
			Completion of residential provider remediation: 50%	**10/17/2021**
			Completion of residential provider remediation: 75%	**1/17/2022**
			Completion of residential provider remediation: 100%	**March 17, 2022**

HCBS CQS July 2018 000788

		Identify remedial action steps (i. e, corrective action plan) for **non-residential** settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment.		
			Completion of non-residential provider remediation: 25%	
			Completion of non-residential provider remediation: 50%	
			Completion of non-residential provider remediation: 75%	
			Completion of non-residential provider remediation: 100%	
		Identification of settings that will not remain in the HCBS System	*Support*	**1/17/2019**
IV	**Heightened Scrutiny (4)**	Identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider		
		Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		
		Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and **release for public comment**		
		Submit STP with Heightened Scrutiny information to CMS for review		**1/1/2019**
		CMS Approval		*3/17/2019*
V	**Relocation (2)**	**Complete** notifying member, guardians, case managers, facility support staff and any other identified responsible parties		**3/17/2021**

HCBS CQS July 2018 000789

		that the setting is not in compliance with HCBS settings requirements and that relocation is required.		
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 25%	
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 50%	
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 75%	
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 100%	
		Complete beneficiary relocation across all providers.		**3/17/2022**
			Complete beneficiary relocation across all providers: 25%	
			Complete beneficiary relocation across all providers: 50%	
			Complete beneficiary relocation across all providers: 75%	
			Complete beneficiary relocation across all providers: 100%	**3/17/2022**

HCBS CQS July 2018 000790

Kennedy, Alice

From: Barry, Sara <Sara.Barry@uvmhealth.org>
Sent: Monday, January 15, 2018 1:23 PM
To: Tierney-Ward, Megan
Subject: RE: Follow up from DAIL presentation

Megan,
Thank you so much for sending along this information. It seems that many of our goals are aligned, particularly around person-centered planning. I'm sure there are a number of ways our teams could work together moving forward. I am going to share these resources with Sarah Jemley, our Care Coordination Program Administrator so she can get up-to-speed in this area as well.
Thanks again!
Sara

From: Tierney-Ward, Megan [mailto:megan.tierney-ward@vermont.gov]
Sent: Thursday, January 11, 2018 10:48 AM
To: Barry, Sara <Sara.Barry@uvmhealth.org>
Subject: Follow up from DAIL presentation

Good morning Sara. Thank you for coming to our management team at DAIL back in December. I am excited to learn more about the training opportunities that we can share in addition to some other potential collaborations. I'm fairly sure the Commissioner's Office is scheduling some follow-up meetings to continue the learning exchange.

I told you I would send some information about the fairly new Federal Medicaid Home and Community-Based Services (HCBS) regulations. They mostly pertain to required elements for person-centered planning and characteristics of an HCBS setting that Medicaid will pay for. We have dedicated a page on our website to our HBCS regulations work plan. I've attached a CMS Fact Sheet and a table that we created to show the regulation elements and how Vermont aligns with those in our Choices for Care program. It shows where we are placing focus to strengthen our alignment with the regulations.

Feel free to roam our web page for other manuals and guidance on our LTSS programs.
http://asd.vermont.gov/

I also wanted to provide you a link to the Vermont Association for Area Agencies on Aging website. They have a page dedicated to their case management training curriculum. My understanding is that the training is open to non AAA case managers for a fee.
http://www.vermont4a.org/

Best,
Megan

Megan Tierney-Ward
Adult Services Division Director

November is National Family Caregiver Month. ***Over 64,000 Vermonters are family caregivers****, providing countless hours of unpaid but essential care to loved ones young and old. Find out more about what it's like to be Caregiving Around the Clock. If you are a caregiver of an older Vermonter, contact the Senior Helpline at* ***1-800-642-5119*** *to learn more about family caregiver training, counseling, peer support, and respite options in your community, and check out these 10 Tips for Family Caregivers.*

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. Thank you.

This message and any attachments may contain information that is confidential, privileged and/or protected from disclosure under state and federal laws. If you received this message in error or through inappropriate means, please reply to this message to notify the Sender that the message was received by you in error, and then permanently delete this message from all storage media, without forwarding or retaining a copy.

HCBS CQS July 2018 000793

FEDERAL HCBS REGULATIONS ASSESSMENT AND IMPLEMENTATION PROJECT

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS) (https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving Medicaid funded services have full access to the benefits of community living and are able to receive services in the most integrated setting. As part of Vermont's Global Commitment to Health (GC) (http://dvha.vermont.gov/global-commitment-to-health/vermont-global-commitment-to-health-approval-documents?portal_status_message=Changes%20saved.) waiver, effective January 30, 2015, CMS has asked Vermont to provide assurances in its Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy) that the State's Managed Long-Term Services and Supports (MLTSS) are in compliance with certain aspects of the HCBS rule, specifically those related to the setting requirement and person- centered approaches for service planning.

- CMS HCBS Regulations (https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider)
- Vermont GC Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy)
- CMS 3-Year Extension Announcement (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-09.html)
- CMS Letter to States (https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf)
- CMS Guidance Website (https://www.medicaid.gov/medicaid/hcbs/guidance/index.html)

Program Documents & Tools

HCBS CQS July 2018 000794

- DAIL Provider Self-Assessment Survey (/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf)
- Choices for Care Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_Choices_for_Care.pdf)
- Choices for Care HCBS Reference Table - Home-Based (/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf)
- Choices for Care Reference Table - Enhanced Residential Care (/sites/asd/files/documents/Regulations_Table_for_ERC.pdf)
- Choices for Care Work Plan (updated December 2016) (/sites/asd/files/documents/Choices_for_Care_HCBS_Work_Plan_Revised_December_2016.pdf)
    - DRAFT Case Management Standards Revision (/sites/asd/files/documents/DRAFT_Case_Management_Standards.pdf)
    - DRAFT List of Case Management Standards Changes (/sites/asd/files/documents/Case%20Management%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Adult Day Standards Revision (/sites/asd/files/documents/DRAFT_Adult_Day_Standards.pdf)
    - DRAFT List of Adult Day Standards Changes (/sites/asd/files/documents/Adult%20Day%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Universal Provider Standards Manual Section (/sites/asd/files/documents/DRAFT%20Universal%20Provider%20Standards%20Manual%20Section.pdf)
    - DRAFT Adult Family Care Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Adult_Family_Care_DRAFT.pdf)
    - DRAFT Rights & Responsibilities Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Rights%26Responsibilities_DRAFT.pdf)
    - DRAFT Live-In Care Agreement Form 808 (/sites/asd/files/documents/CFC_LiveIn_Requirements%20808%20Form%20DRAFT.pdf)
    - FINAL Case Management Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf)
    - FINAL Adult Day Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Adult_Day_Standards_January_2017.pdf)
- TBI Program Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_TBI.pdf)

HCBS CQS July 2018 000795

- TBI Program Reference Table (/sites/asd/files/documents/TBI_Reference_Table_HCBS_Regs.pdf)
- TBI Program Work Plan (/sites/asd/files/documents/TBI_HCBS_Work_Plan.pdf)

TAGS:
Human Rights (/tags/human-rights) |
Long Term Services and Supports (/tags/long-term-services-and-supports) |
Medicaid (/tags/medicaid) | Standards (/tags/standards)

Contact Us

Megan Tierney-Ward, Division Director
HC 2 South, 280 State Drive
Waterbury, VT 05671-2070
Voice: (802) 241-0294
Fax: (802) 241-0385
For Telecommunications Relay Service: Dial 711

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(http://asd.vermont.gov/help)

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How to get help for you, a friend, or a loved one. (http://asd.vermont.gov/help)

(http://asd.vermont.gov/services)

Services

List of Services and Providers throughout the State (http://asd.vermont.gov/services)

(http://asd.vermont.gov/help/repc a-concern)

Report a Concern

Concerns about Adult Abuse, Neglect or Exploitation, Quality of Care, Medicaid Fraud and more. (http://asd.vermont.gov/help/rep a-concern)

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We are the association of five non-profit Area Agencies on Aging located throughout Vermont to respond to the needs and directions of older Vermonters and their families by offering information and assistance in many areas. We can share available options for caregiver support, health insurance counseling, transportation, senior nutrition programs including meals on wheels, adult day programs, home health services, housing alternatives, exercise and wellness programs and supports for Veterans to live independently in their own homes.

Who We Are

Our mission is to ensure that all Vermonters age with health, independence and dignity by strengthening the capacity of the Area Agencies on Aging.

Click on any of the logos of the Area Agencies on Aging below to be re-directed to their home page.

HERE.

CENTRAL VERMONT Council on Aging

NORTHEAST KINGDOM Council on Aging
New directions for living well.

Senior SOLUTIONS
Council on Aging for Southeastern Vermont

Where We Are Located

The map below indicates where our five Area Agencies on Aging are located.

To reach your local agency, call our HELPLINE for assistance at

1-800-642-5119

Age Well
mplain Valley Agency on
n, Chittenden, Franklin &
le Counties (Except
ns of Granville and
Hancock)
02-865-0360
v.agewellvt.org

Northeast Kingdom Council on
Caledonia, Essex & Or
Counties
802-748-5182
www.nekcouncil.o

Central Vermont Council on Aging
Lamoille, Orange,
& Washington Counties
(For all towns in these counties except Thetford.
Includes Granville, Hancock, Pittsfield, Bethel, Rochester, Royalton, Sharon and Stockbridge)

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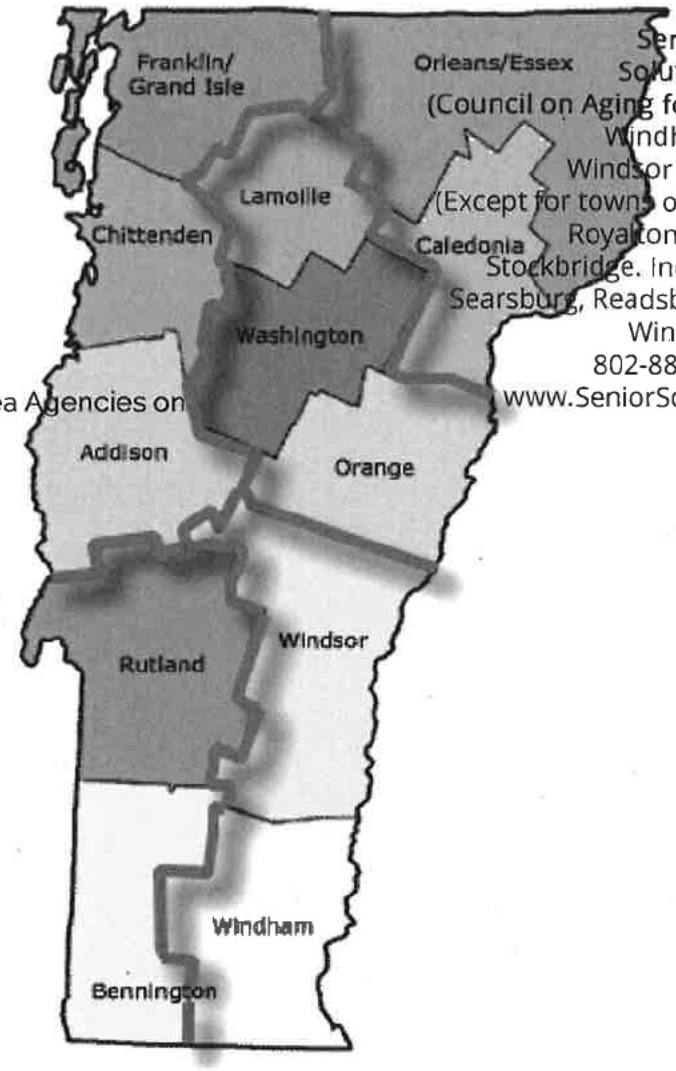
ouncil on Aging
on & Rutland
unties
of Pittsfield, Winhall,
dsboro,
rsburg)
786-5990
svcoa.org



877-379-2600
www.cvcoa.org

Senior Solutions
(Council on Aging for Southeastern VT)
Windham &
Windsor Counties
(Except for towns of Bethel, Rochester,
Royalton, Sharon,
Stockbridge. Includes towns of
Searsburg, Readsburg, Thetford and
Winhall)
802-885-2655
www.SeniorSolutionsVT.org

rmont Association of Area Agencies on
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rmont 05404
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SUPPORT AND SERVICES AT HOME
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Kennedy, Alice

From: Skaflestad, Shawn
Sent: Tuesday, April 03, 2018 11:29 AM
To: Harrigan, Emma; Reed, Frank; Tierney-Ward, Megan; Courcelle, Andre; McFadden, Clare; Omland, Laurel; Clark, Bill
Cc: O'Neill, Chris; Robson, Dana; Singer, Patricia
Subject: RE: HCBS CQS/STP Implementation
Attachments: VT Milestone Template April 3, 2018.docx

Hi All – attached is the updated HCBS Implementation Milestone Template. Please take a look and let me know if you anticipate any issues with the deadlines proposed. I would like to send this to CMS by the end of the week – so feedback before cob Friday, April 6th would be appreciated.

Thank you,

Shawn

-----Original Appointment-----
From: Skaflestad, Shawn
Sent: Wednesday, December 13, 2017 10:05 AM
To: Skaflestad, Shawn; Harrigan, Emma; Reed, Frank; Parro, Lisa; Tierney-Ward, Megan; Courcelle, Andre; McFadden, Clare; Omland, Laurel; Clark, Bill
Cc: O'Neill, Chris; Robson, Dana; Singer, Patricia
Subject: HCBS CQS/STP Implementation
When: Wednesday, March 21, 2018 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: AHS - WSOC FirA 10 OR Dial-In Number: 1-877-273-4202 Conference Room ID: 1262904

Hi All, I am scheduling this meeting once per month for the first 6 months of 2018 to discuss issues related to HCBS CQS/STP implementation. Shawn

SECTION	TOPIC	MILESTONE	SUB-MILESTONE	DUE DATE
I	**Systemic Assessment and Remediation**	Completion of systemic assessment		**Done**
		Modify rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.		
			Implementation of new rules and regulations: 50% complete	**Done**
			Implementation of new rules and regulations: 100% complete	**Done**
II	**Site-specific Assessments**	Completion of site-specific assessment		**9/17/2018**
III	**Validation Activities**	Identify plan to validate results/outcomes of site specific settings assessment.		**Done**
		Completion of validation activities		**9/17/2018**
		Once the state's validation activities have been completed, provide an updated chart of the number of sites falling into categories of compliance (a) fully compliant with the settings criteria, (b) could come into full compliance with modifications, (c) cannot comply with the federal settings criteria, or (d) are presumptively institutional in nature.		**10/17/2018**
		Identification of settings that will not remain in the HCBS System		**10/17/2018**
IV	**Heightened Scrutiny**	Identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider		**10/17/18**
		Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		**11/17/18**
		Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for **public comment**		**11/17/18**

HCBS CQS July 2018 000804

V	**Ongoing Monitoring of the Settings**	Provide information on the estimated timeframes for implementing each element of the oversight and monitoring plan.		**11/17/18**
VI	**Site-specific Remediation: Planning**	Identify remedial action steps (i.e., corrective action plan) for settings based on site specific settings assessment and validation activity.		**11/17/2018**
		Incorporate results of settings analysis into final version of the STP and release for **public comment**		**11/17/2018**
VII	**CMS Submission**	Submit STP with Heightened Scrutiny information to CMS for review		**1/17/2019**
		Submit STP to CMS for Final Approval		**1/17/2019**
		CMS Approval		***3/17/2019***
VIII	**Site-specific Remediation: Implementation**	Manage site-specific Remediation		
			Completion of provider remediation: 25%	**7/17/2021**
			Completion of provider remediation: 50%	**10/17/2021**
			Completion of provider remediation: 75%	**1/17/2022**
			Completion of provider remediation: 100%	**3/17/2022**
IX	**Notification**	Notify member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required.		
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 25%	**6/17/2020**
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 50%	**9/17/2020**

HCBS CQS July 2018 000805

			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 75%	**12/17/2020**
			Complete notification that setting is not in compliance with HCBS settings requirements and that relocation is required: 100%	**3/17/2021**
X	**Relocation**	Relocate beneficiaries across all providers.		
			Complete beneficiary relocation across all providers: 25%	**6/17/2021**
			Complete beneficiary relocation across all providers: 50%	**9/17/2021**
			Complete beneficiary relocation across all providers: 75%	**12/17/2021**
			Complete beneficiary relocation across all providers: 100%	**3/17/2022**

Kennedy, Alice

From: Rogers, Jackie
Sent: Thursday, November 02, 2017 12:07 PM
To: Tierney-Ward, Megan
Subject: Re: HCBS provider validation consumer survey

Yes. She is only working very part time for me.

Get Outlook for iOS

From: Tierney-Ward, Megan
Sent: Thursday, November 2, 2017 9:54:49 AM
To: Rogers, Jackie
Subject: FW: HCBS provider validation consumer survey

Hi Jackie!

A birdy told me that Kathy Hamilton is working with you as a temp. You can see the email below that ASD is starting work on some HCBS regulations work that Kathy has experience doing with DS. I'm interested to know if Kathy is potentially available to help us on a time-limited project.

Thanks,
Megan

From: McFadden, Clare
Sent: Wednesday, November 01, 2017 4:27 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: HCBS provider validation consumer survey

OK, I checked in with Kathy Hamilton and with Chris O'Neil about the status of validation surveys. Here's what I learned. Kathy only did the agency surveys. Those are complete and we have a summary of the findings. Chris's QM team is doing the validation surveys with consumers during their regularly scheduled quality review process as each agency comes due for review. He has imbedded questions to determine compliance with HCBS into the interview process with consumers. The have used this process with 2 agencies so far. His plan is to compare the information submitted during the agency review and compare it to the information provided by consumers. He will also be looking to see if the agency has implemented the changes they said they would make in the agency survey. His plan is to include a section in the quality review report to the agency regarding HCBS compliance and need for a POC for things that still do not meet the requirements. Kathy was not going to be used for the consumer survey validation process. Kathy is hired as a temporary employee. She is now working with Jackie on some work for OPG. I'm not sure how long we will have her on board.

Let me know if you have other questions. I still need to get fully up to speed on the requirements and I need to work with Chris around the workplan for completing everything and then ensuring an ongoing review process. We still also need to map out our plan for reviewing settings that are at risk of not being in compliance.

From: Tierney-Ward, Megan
Sent: Friday, October 27, 2017 10:30 AM
To: McFadden, Clare <Clare.McFadden@vermont.gov>
Subject: RE: HCBS provider validation consumer survey

Thank you Clare!

From: McFadden, Clare
Sent: Friday, October 27, 2017 10:06 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: HCBS provider validation consumer survey

Hi Megan- I need to get up to speed on what has been done and our next steps. I am going to research this now and I'll get back to you next week.

From: Tierney-Ward, Megan
Sent: Wednesday, October 25, 2017 3:46 PM
To: McFadden, Clare <Clare.McFadden@vermont.gov>
Subject: HCBS provider validation consumer survey

Hi Clare,
Did DS already complete the HCBS regulations validation survey with consumers? I know that Roy was working with Kathy Hamilton to do that work. We are getting ready to do ours and are interested to know if it went well with Kathy and what your payment agreement looked like if you can share it.

Thanks!
M

Megan Tierney-Ward
Adult Services Division Director

Falls are the leading cause of fatal and non-fatal injuries among older adults, but you have the power to prevent a fall. September is ***Falls Prevention Awareness Month***! Learn more at Falls Free Vermont or by calling the Senior Helpline at 1-800-642-5119.

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385

megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. Thank you.

Kennedy, Alice

From: Ash, Kate (Leahy) <Kate_Ash@leahy.senate.gov>
Sent: Friday, December 22, 2017 9:37 AM
To: Tierney-Ward, Megan
Subject: RE: HCBS regs, olmstead and cfc

Hi Megan,

It looks like we are playing a game of phone tag – for which I apologize. I had to get on the road immediately after the DAIL call yesterday so apologize for missing you. Are you available prior to 11:30 today to chat briefly? My number is 802-863-2525.

Thanks,
Kate

From: Tierney-Ward, Megan [mailto:megan.tierney-ward@vermont.gov]
Sent: Wednesday, December 20, 2017 1:54 PM
To: Ash, Kate (Leahy) <Kate_Ash@leahy.senate.gov>
Subject: HCBS regs, olmstead and cfc

Hi Kate,
I left you a message on your cell phone. I am passing along some information about the federal CMS HCBS regulations, Olmstead and Choices for Care.

The Agency of Human Services is working with each Department on work plans to implement and manage the new HCBS regulations. The two key areas are settings requirements and person centered planning. This does relate to Olmstead in that the HCBS rules require the person to decide where to receive their services based on what services are available in the State.

Here is a link to our program specific HCBS assessments and work plans related to the CMS HCBS regulations: http://asd.vermont.gov/special-projects/federal-hcbs.

Please let me know if you have any other questions.

Megan Tierney-Ward
Adult Services Division Director

November is National Family Caregiver Month. ***Over 64,000 Vermonters are family caregivers****, providing countless hours of unpaid but essential care to loved ones young and old. Find out more about what it's like to be Caregiving Around the Clock. If you are a caregiver of an older Vermonter, contact the Senior Helpline at* ***1-800-642-5119*** *to learn more about family caregiver training, counseling, peer support, and respite options in your community, and check out these 10 Tips for Family Caregivers.*

NEW ASD Website: http://asd.vermont.gov/
NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South

Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. Thank you.

HCBS CQS July 2018 000812

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FEDERAL HCBS REGULATIONS ASSESSMENT AND IMPLEMENTATION PROJECT

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS) (https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving Medicaid funded services have full access to the benefits of community living and are able to receive services in the most integrated setting. As part of Vermont's Global Commitment to Health (GC) (http://dvha.vermont.gov/global-commitment-to-health/vermont-global-commitment-to-health-approval-documents?portal_status_message=Changes%20saved.) waiver, effective January 30, 2015, CMS has asked Vermont to provide assurances in its Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy) that the State's Managed Long-Term Services and Supports (MLTSS) are in compliance with certain aspects of the HCBS rule, specifically those related to the setting requirement and person- centered approaches for service planning.

- CMS HCBS Regulations (https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider)
- Vermont GC Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy)
- CMS 3-Year Extension Announcement (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-09.html)
- CMS Letter to States (https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf)
- CMS Guidance Website (https://www.medicaid.gov/medicaid/hcbs/guidance/index.html)

Program Documents & Tools

- DAIL Provider Self-Assessment Survey (/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf)
- Choices for Care Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_Choices_for_Care.pdf)
- Choices for Care HCBS Reference Table - Home-Based (/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf)
- Choices for Care Reference Table - Enhanced Residential Care (/sites/asd/files/documents/Regulations_Table_for_ERC.pdf)
- Choices for Care Work Plan (updated December 2016) (/sites/asd/files/documents/Choices_for_Care_HCBS_Work_Plan_Revised_December_2016.pdf)
    - DRAFT Case Management Standards Revision (/sites/asd/files/documents/DRAFT_Case_Management_Standards.pdf)
    - DRAFT List of Case Management Standards Changes (/sites/asd/files/documents/Case%20Management%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Adult Day Standards Revision (/sites/asd/files/documents/DRAFT_Adult_Day_Standards.pdf)
    - DRAFT List of Adult Day Standards Changes (/sites/asd/files/documents/Adult%20Day%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Universal Provider Standards Manual Section (/sites/asd/files/documents/DRAFT%20Universal%20Provider%20Standards%20Manual%20Section.pdf)
    - DRAFT Adult Family Care Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Adult_Family_Care_DRAFT.pdf)
    - DRAFT Rights & Responsibilities Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Rights%26Responsibilities_DRAFT.pdf)
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    - FINAL Adult Day Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Adult_Day_Standards_January_2017.pdf)
- TBI Program Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_TBI.pdf)

- TBI Program Reference Table (/sites/asd/files/documents/TBI_Reference_Table_HCBS_Regs.pdf)
- TBI Program Work Plan (/sites/asd/files/documents/TBI_HCBS_Work_Plan.pdf)

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Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Wednesday, May 16, 2018 8:49 AM
To: McMann, Angela
Cc: Courcelle, Andre
Subject: RE: Heightened scrutiny

Not yet. We might have an adult day center in Newport that is co-located in a nursing home. They have until next year to comply. Our state is also unique in that we do not include ERC in our HCBS regulations compliance because they are considered "PNMI" or private non-medical institution. We will, however, apply elements of the HCBS regulations in our quality and future regulations changes if it makes sense.

Andre is our lead on this and can keep you abreast.

Megan

From: McMann, Angela
Sent: Tuesday, May 15, 2018 4:07 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: Heightened scrutiny

Have we assessed settings for heightened scrutiny?

Angela McMann, PT
Aging & Disabilities Program Manager
Department of Disabilities, Aging & Independent Living
Adult Services Division
HC 2 South
280 State Drive
Waterbury, VT 05671-2070

Email: angela.mcmann@vermont.gov
Office: (802)241-0292
Cell: (802)793-6986

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Wednesday, July 26, 2017 11:33 AM
To: Senghas, Stuart
Subject: RE: Meeting

It is a part of the CMS regulations that say what HCBS is NOT. It is on the bottom of our HCBS reference table and can be found on the CMS website as well.

HCBS Reference Table: http://asd.vermont.gov/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf

CMS Regulations: https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

(2) Home and community-based settings do not include the following:
(i) A nursing facility.
(ii) An institution for mental diseases.
(iii) An intermediate care facility for individuals with intellectual disabilities.
(iv) A hospital.
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

From: Senghas, Stuart
Sent: Wednesday, July 26, 2017 11:26 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: Meeting

Megan,

I am having difficulty finding the HCBS criteria related to co-location in regards to Adult Days.

Can you point me in the right direction around this.

Also, is there a time later this afternoon we can connect around Green Mt. Adult Day?

Thanks,

Stuart

Stuart Senghas, MSW
Quality and Program Participant Specialist
Adult Services Division
Department of Disabilities, Aging, & Independent Living

280 State Dr., HC 2 South, Waterbury, VT 05671-2070
Desk: 802-241-0307
Cell: 802-585-5730
Fax: 802-241-0385
Email: stuart.senghas@vermont.gov

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For information, referral and assistance for adult Vermonters, contact your Aging & Disabilities Resource Connections/No Wrong Door partner:

- Vermont 211: Dial 211
- Senior Helpline: 1-800-642-5119 (for people 60 and older)
- VT Center for Independent Living: 1-800-639-1522 (for people under 60)
- Brain Injury Association of VT: 1-877-856-1772

Choices for Care: Application of Federal Rules

Home-Based Settings Reference Table

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	✓	✓	N/A
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	✓	✓	N/A
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	✓	✓	N/A
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	✓	✓	N/A
5. Facilitates individual choice regarding services and supports, *and who provides them*	✓	✓	N/A
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a	✓	N/A	N/A

HCBS CQS July 2018 000819

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*			
7. Each individual has privacy in their sleeping or living unit	✓	N/A	N/A
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	✓✪	N/A	N/A
9. Individuals sharing units have a choice of roommates in that setting	✓	N/A	N/A
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	✓✪	N/A	N/A
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	✓✪	✓	N/A
12. Individuals are able to have visitors of their choosing *at any time*	✓✪	✓✪	N/A
13. The setting is physically accessible to the individual	✓	✓	N/A
14. Modification to HCBS Settings Requirements	✓✪	✓✪	N/A

HCBS CQS July 2018 000820

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
1. Includes people chosen by the individual and led by person or legal rep where possible	✓	✓	✓
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	✓	✓	✓
3. Is timely, occurs at times and locations of convenience to the individual	✓✪	✓	✓✪
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	✓	✓	✓
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	✓	✓	✓
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*	✓✪	✓✪	✓✪
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	✓	✓	✓
8. Includes a method for the individual to request updates to the plan as needed	✓	✓	✓
9. Records the alternative home- and community-based settings that were considered by the individual	✓	N/A	✓

HCBS CQS July 2018 000821

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
10. Reflect that the setting in which the individual resides is chosen by the individual.	✓✪	✓	✓✪
11. Reflect the individual's strengths and preferences	✓	✓	✓
12. Reflect needs identified through functional assessments	✓	✓	✓
13. Include individually identified goals and desired outcomes	✓	✓	✓
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	✓	✓	✓
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	✓	✓	✓
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	✓	✓	✓
17. Identify the individual and/or entity responsible for monitoring the plan	✓	✓	✓
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	✓	✓	✓
19. Be distributed to the individual and other people involved in the plan	✓	✓	✓
20. Include those services, the purpose or control of which the individual elects to self-direct	✓	✓	✓
21. Prevent the provision of unnecessary or inappropriate services and supports	✓	✓	✓
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or	✓	✓	✓

HCBS CQS July 2018 000822

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
at the request of the individual			
23. Modifications to the Person-Centered Plan	✓ ✪	✓ ✪	✓ ✪

NOTE: Per CMS Regulations 42 CFR Section 441:

(2) Home and community-based settings do not include the following:
(i) A nursing facility.
(ii) An institution for mental diseases.
(iii) An intermediate care facility for individuals with intellectual disabilities.
(iv) A hospital.
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

HCBS CQS July 2018 000823

LEGAL STATUS

LEGAL STATUS

Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers

A Rule by the Centers for Medicare & Medicaid Services on 01/16/2014

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ENHANCED CONTENT

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ENHANCED CONTENT

PUBLISHED DOCUMENT

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AGENCY:

Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION:

Final rule.

SUMMARY:

This final rule amends the Medicaid regulations to define and describe state plan section 1915(i) home and community-based services (HCBS) under the Social Security Act (the Act) amended by the Affordable Care Act. This rule offers states new flexibilities in providing necessary and appropriate services to elderly and disabled populations. This rule describes Medicaid coverage of the optional state plan benefit to furnish home and community based-services and draw federal matching funds.

This rule also provides for a 5-year duration for certain demonstration projects or waivers at the discretion of the Secretary, when they provide medical assistance for individuals dually eligible for Medicaid and Medicare benefits, includes payment reassignment provisions because state Medicaid programs often operate as the primary or only payer for the class of practitioners that includes HCBS providers, and amends Medicaid regulations to provide home and community-based setting requirements related to the Affordable Care Act for Community First Choice State plan option. This final rule also makes several important changes to the regulations implementing Medicaid 1915(c) HCBS waivers.

DATES:

Effective Date: These regulations are effective on March 17, 2014.

FOR FURTHER INFORMATION CONTACT:

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Regulation Text

Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding terms in alphabetical order below.

ADA Americans with Disabilities Act of 1990 (Pub. L. 110-325 (https://api.fdsys.gov/link?collection=plaw&congress=110&lawtype=public&lawnum=325&link-type=html))

ADLs Activities of daily living

AHRQ Agency for Healthcare Research and Quality

ANPRM Advance Notice of Proposed Rulemaking

CFC Community First Choice (1915(k) State plan Option)

CHIPRA Children's Health Insurance Program Reauthorization of 2009 (Pub. L. 111-3 (https://api.fdsys.gov/link?collection=plaw&congress=111&lawtype=public&lawnum=3&link-type=html))

CMS Centers for Medicare & Medicaid Services

DRA Deficit Reduction Act of 2005 (Pub. L. 109-171 (https://api.fdsys.gov/link?collection=plaw&congress=109&lawtype=public&lawnum=171&link-type=html))

EPSDT Early and Periodic Screening, Diagnosis and Treatment

FBR Federal benefit rate

FFP Federal financial participation

FPL Federal poverty line

FY Federal fiscal year

HCB Home and community based

HCBS Home and Community-Based Services

HHS Department of Health and Human Services

IADLs Instrumental activities of daily living

ICF/IID Intermediate care facility for individuals with intellectual disabilities

LOC Level of care

NF Nursing facility

OBRA`81 Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35)

OT Occupational therapy

PT Physical therapy

RFA Regulatory Flexibility Act

SPA State Plan Amendments

SSI Supplemental Security Income

SSI/FBR Supplemental Security Income Federal Benefit Rate

UPL Upper payment limit

I. Executive Summary

A. Purpose

This final rule amends Medicaid regulations consistent with the requirements of section 2601 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), which added section 1915(h)(2) to the Act to provide authority for a 5-year duration for certain demonstration projects or waivers under sections 1115, 1915(b), (c), or (d) of the Act, at the discretion of the Secretary, when they provide medical assistance to individuals who are dually eligible for both Medicaid and Medicare benefits.

This final rule also provides additional limited exception to the general requirement that payment for services under a state plan must be made directly to the individual practitioner providing a service when the Medicaid program is the primary source of reimbursement for a class of individual practitioners. This exception will allow payments to be made to other parties to benefit the providers by ensuring workforce stability, health and welfare, and trainings, and provide added flexibility to the state. We are including the payment reassignment provision, because states' Medicaid programs often operate as the primary or only payer for the class of practitioners that includes HCBS providers.

In addition, this final rule also amends Medicaid regulations to provide home and community-based setting requirements related to section 2401 of the Affordable Care Act for section 1915(k) of the Act, the Community First Choice State plan option.

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This final rule further amends the Medicaid regulations to define and describe state plan home and community-based services (HCBS). This regulation outlines the optional state plan benefit to furnish home and community-based state plan services and draw federal matching funds. As a result, states will be able to design and tailor Medicaid services to better accommodate individual needs. This may result in improved patient outcomes and satisfaction, while enabling states to effectively manage their Medicaid resources.

This final rule also revises the regulations implementing Medicaid home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act (the Act) by providing states the option to combine the existing three waiver targeting groups identified in § 441.301. In addition, this final rule will include other changes to the HCBS waiver provisions to convey expectations regarding person-centered plans of care, to provide characteristics of settings that are home and community-based as well as settings that may not be home and community-based, to clarify the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and to describe the additional strategies available to CMS to ensure state compliance with the statutory provisions of section 1915(c) of the Act. The final rule also includes requirements for person-centered plans of care that document, among other things, an individual's choice of a HCB setting from among options that meet the individual's needs.

B. Summary of the Major Provisions

1. STATE PLAN HOME COMMUNITY-BASED SERVICES (SECTION 1915(I) OF THE ACT)

The Deficit Reduction Act (DRA) added a new provision to the Medicaid statute entitled "Expanded Access to Home and Community-Based Services for the Elderly and Disabled." This provision allows states to provide HCBS (as an optional program) under their state Medicaid plans. This option allows states to receive federal financial participation for services that were previously eligible for federal funds only under waiver or demonstration projects. This provision was further amended by the Affordable Care Act. The statute now provides additional options for states to design and implement HCBS under the Medicaid state plan. In the April 4, 2008, **Federal Register**, (73 FR 18676 (/citation/73-FR-18676)) we published a proposed rule to amend Medicaid regulations to implement HCBS under the DRA. That proposed rule was not finalized, and with the passage of section 2402 of the Affordable Care Act, some previously proposed regulations would no longer be in compliance with the current law under section 1915(i) of the Act. In addition, several new provisions were added. Specifically, the Affordable Care Act amended the statute by adding a new optional categorical eligibility group for individuals to provide full Medicaid benefits to certain individuals who will be receiving HCBS. It also authorized states to elect not to comply with section 1902(a)(10)(B) of the Act pertaining to comparability of Medicaid services. After closely analyzing the Affordable Care Act provisions, we concluded that a new proposed rule was necessary. This final rule also establishes home and community-based setting requirements. We will allow states a transition/phase-in period for current approved 1915(i) State plan HCBS to demonstrate compliance with these requirements.

2. 5-YEAR PERIOD FOR CERTAIN DEMONSTRATION PROJECTS AND WAIVERS

This final rule provides for a 5-year approval or renewal period, subject to the discretion of the Secretary, for certain Medicaid waivers. Specifically, this time period applies for demonstration and waiver programs through which a state serves individuals who are dually eligible for both Medicare and Medicaid benefits.

3. PROVIDER PAYMENT REASSIGNMENTS

Section 1902(a)(32) of the Act provides that state plans can allow payments to be made only to certain individuals or entities. Specifically, payment may only be made to an individual practitioner who provided the service. The statute provides several specific exceptions to the general principle of direct payment to the individual practitioner.

Over the years, some states have requested that we consider adopting additional exceptions to the direct payment principle to permit withholding from the payment due to the individual practitioner for amounts paid by the state directly to third parties for health and welfare benefits, training costs and other benefits customary for employees. These amounts would not be retained by the state, but would be remitted to third parties on behalf of the practitioner for the stated purpose.

While the statute does not expressly provide for additional exceptions to the direct payment principle, we believe the circumstances at issue were not contemplated under the statute. Therefore, we proposed that the direct payment principle should not apply because we think its application would contravene the fundamental purpose of this provision. The apparent purpose of the direct payment principle was to prohibit factoring arrangements, and not to preclude a Medicaid program that is functioning as the practitioner's primary source of revenue from fulfilling the basic responsibilities that are associated with that role. Therefore, we proposed an additional exception to describe payments that we do not see as within the intended scope of the statutory direct payment requirement, that would allow the state to claim as a provider payment amounts that are not directly paid to the provider, but are withheld and remitted to a third party on behalf of the provider for health and welfare benefit contributions, training costs, and other benefits customary for employees.

4. COMMUNITY FIRST CHOICE STATE PLAN OPTION: HOME AND COMMUNITY-BASED SETTING REQUIREMENTS (SECTION 1915(K) OF THE ACT)

Section 1915(k)(1)(A)(ii) of the Act provides that home and community-based attendant services and supports must be provided in a home and community-based setting. The statute specifies that home and community-based settings do not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities. We have adopted this statutory language in our regulations. Additionally, to provide greater clarity, we have established that home and community-based settings must exhibit specific qualities to be eligible sites for delivery of home and community-based services.

After consideration of comments received in response to the Community First Choice (CFC) proposed rule published in the **Federal Register** (76 FR 10736 (/citation/76-FR-10736)) on February 25, 2011, we decided to revise the setting provision and publish our proposed definition as a new proposed rule to allow for additional public comment before this final rule. The public comment process has been valuable in assisting us to develop the best policy on this issue for Medicaid beneficiaries. We have fully considered all comments received, and have aligned the requirements pertaining to home and community-based settings across CFC, section 1915(i) State plan HCBS, and section 1915(c) of the Act HCBS waivers.

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5. HOME AND COMMUNITY BASED SERVICES WAIVERS (SECTION 1915(C) OF THE ACT)

Section 1915(c) of the Act authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements so that a state may offer Home and Community-Based Services (HCBS) to state-specified group(s) of Medicaid beneficiaries who otherwise would require services at an institutional level of care. This final rule will give states the option to combine the existing three waiver targeting groups as identified in § 441.301. In addition, it will implement requirements regarding person-centered service plans, clarify the timing of amendments when states modify HCBS waiver programs and service rates, and describe the additional strategies available to us to ensure state compliance with the provisions of section 1915(c) of the Act. This final rule also establishes home and community-based setting requirements. We will allow states a transition/phase-in period for current approved 1915(c) HCBS waivers to demonstrate compliance with these requirements.

C. Summary of Costs, Benefits and Transfers

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Provision description	Total costs	Total benefits	Total transfers
1915(i) State Plan Home Community-Based Services	The estimated total annual collection of information requirements cost to states is $21,805.	We anticipate that states will make varying use of the state plan HCBS benefit provisions to provide needed long-term care services for Medicaid beneficiaries. These services will be provided in the home or alternative living arrangements in the community, which is of benefit to the beneficiary, and is less costly than institutional care.	We estimate that, adjusted for a phase-in period during which states gradually elect to offer the state plan HCBS benefit, in FY 2014 the federal cost would be $150 million, and the estimated state cost would be $115million. (Some portion of these impacts would actually be societal costs rather than "transfers", to the extent that new users of the HCBS in this rule are previously not receiving services.)
Section 2601 of the Affordable Care Act: 5-Year Period for Demonstration Projects (Waivers)	N/A	As this provision elongates the time period under which states may operate certain waiver programs without renewal, it will help states to minimize administrative and renewal requirements in order to better focus on program implementation and quality oversight.	No impact on federal or state Medicaid funding. This rule is voluntary on the part of states.
Provider Payment Reassignments	N/A	This rule implements additional operational flexibilities for states to help ensure a strong provider workforce.	We do not anticipate any impact on federal Medicaid funding. This rule is voluntary on the part of states.
Section 2401 of the Affordable Care Act: Community First Choice State Plan Option: Home and Community-Based Setting Requirements	N/A	This rule provides states with necessary guidance to support compliance with the requirement that CFC services are provided in a home or community based-setting. This rule also provides beneficiary protections to support an individual's choice to receive HCBS in a manner that allows for integration with the greater community.	We do not anticipate there is an impact on federal or state Medicaid funding, as the purpose of the rule is merely to define home and community-based settings in which CFC services may be provided.

Provision description	Total costs	Total benefits	Total transfers
1915(c) Home and Community-Based Services Waivers	States may incur costs in coming into compliance with this rule. Given the variability in state programs, and the varying extent to which some are already complying, it is difficult to estimate these costs.	These changes will support beneficiaries by enabling services to be planned and delivered in a manner driven by the beneficiary and will maximize opportunities for beneficiaries to have access to the benefits of community living and receive services in the most integrated setting. These changes will also enable states to realize administrative and program design simplification and improve efficiency of operation.	We do not anticipate any impact on federal Medicaid funding.

II. State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice

A. Background

On February 8, 2006, the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109-171 (https://api.fdsys.gov/link?collection=plaw&congress=109&lawtype=public&lawnum=171&link-type=html)) was signed into law. Section 6086 of the DRA is entitled "Expanded Access to Home and Community-Based Services for the Elderly and Disabled." Section 6086(a) of the DRA adds a new section 1915(i) to the Act that allows states, at their option, to provide home and community-based services (HCBS) under their regular state Medicaid plans. This option allows states to receive federal financial participation (FFP) for services that were previously eligible for the funds only under waiver or demonstration projects, including those under sections 1915(c) and 1115 of the Act. Section 1915(i) of the Act was later amended by sections 2402(b) through (g) of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148 (https://api.fdsys.gov/link?collection=plaw&congress=111&lawtype=public&lawnum=148&link-type=html), enacted March 23, 2010) (Affordable Care Act) to provide additional options for states to design and implement HCBS under the Medicaid state plan.

In the following discussion of this regulation, we refer to particular home and community-based service(s) offered under section 1915(i) of the Act as "State plan HCBS" or simply "HCBS" [1]. We refer to the "State plan HCBS benefit" when describing the collective requirements of section 1915(i) of the Act that apply to states electing to provide one, or several, of the authorized HCBS. We choose to use the term "benefit" rather than "program" to describe section 1915(i) of the Act to avoid possible confusion with section 1915(c) HCBS waiver programs. The State plan HCBS benefit shares many features with section 1915(c) waiver programs, but it is a state plan benefit, although one with very unique features not common to traditional state plan services.

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Under section 1915(i) of the Act, states can provide HCBS to individuals who require less than institutional level of care (LOC) and who would, therefore, not be eligible for HCBS under section 1915(c) waivers, in addition to serving individuals who have needs that would meet entry requirements for an institution. As with other state plan services, the benefits must be provided statewide, and states must not limit the number of eligible people served.

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Section 1915(i) of the Act explicitly provides that State plan HCBS may be provided without determining that, but for the provision of these services, individuals would require the LOC provided in a hospital, a nursing facility (NF), or an intermediate care facility for individuals with intellectual disabilities [2] (ICF/IID) as is required in section 1915(c) HCBS waivers. While HCBS provided through section 1915(c) waivers must be "cost-neutral", as compared to institutional services, no cost neutrality requirement applies to the section 1915(i) State plan HCBS benefit. States are not required to produce comparative cost estimates of institutional care and the State plan HCBS benefit. This significant distinction allows states to offer HCBS to individuals whose needs are substantial, but not severe enough to qualify them for institutional or waiver services, and to individuals for whom there is not an offset for cost savings in NFs, ICFs/MR, or hospitals.

To be eligible for the State plan HCBS benefit, an individual must be included in an eligibility group that is contained in the state plan, including if the state elects, the new eligibility group defined at section 1902(a)(10)(A)(ii)(XXII) of the Act. Each individual must meet all financial and non-financial criteria set forth in the plan for the applicable eligibility group.

HCBS benefits that are not otherwise available through section 1905(a) of the Act state plan services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit may be furnished to Medicaid eligible children who meet the State plan HCBS needs-based eligibility criteria, and who meet the state's medical necessity criteria for the receipt of services. In addition to meeting EPSDT requirements through the provision of 1905(a) services, a state may also meet, in part, a particular child's needs under EPSDT through services that are also available through the 1915(i) benefit. However, all Medicaid-eligible children must have full access to services required under EPSDT, and the provision of 1915(i) State plan HCBS should in no way hinder their access to such services.

Section 1915(i)(1)(H)(i) of the Act requires the state to ensure that the State plan HCBS benefit meets federal and state guidelines for quality assurance, which we interpret as assurances of quality improvement. Consistent with current trends in health care, the language of quality assurance has evolved to mean quality improvement, a systems approach designed to continuously improve services and support and prevent or minimize problems prior to occurrences. Guidelines for quality improvement have been made available through CMS policies governing section 1915(c) HCBS waivers available at *www.hcbswaivers.net (http://www.hcbswaivers.net)* and published manuscripts available at *www.nationalqualityenterprise.com (http://www.nationalqualityenterprise.com).*

Section 1915(i) provides states the option to provide home and community-based services, but does not define "home and community-based." Along with our overarching goal to improve Medicaid HCBS, we seek to ensure that Medicaid is supporting needed strategies for states in their efforts to meet their obligations under the ADA and the Supreme Court decision in *Olmstead* v. *L.C.*, 527 U.S. 581 (1999). In the *Olmstead* decision, the Court affirmed a state's obligations to provide covered program services to eligible individuals with disabilities in the most integrated setting appropriate to their needs. A state's obligations under the ADA and section 504 of the Rehabilitation Act are not defined by, or limited to, the services provided under the State's Medicaid program. However, the Medicaid program can support compliance with the ADA, section 504 of the Rehabilitation Act, and *Olmstead* through the provision of Medicaid services to Medicaid-eligible individuals in integrated settings.

We noted in the May 3, 2012 proposed rule published in the **Federal Register** (77 FR 26362 (/citation/77-FR-26362)), that home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for the mentally retarded, hospitals, or any other locations that have the qualities of an institutional setting as determined by the Secretary.

While HCBS are not available while an individual resides in an institution, HCBS may be available to assist individuals to transition from an institution to the community. Recognizing that individuals leaving institutions require assistance to establish themselves in the community, we would allow states to include in a section 1915(i) benefit, as an "other" service, certain transition services to be offered to individuals to assist them in their transition to the community. We proposed that community transition services could be commenced prior to discharge and could be used to assist individuals during the period of transition from an institutional residence. Additionally, services could be provided to assist individuals transitioning to independent living in the community, as described in a letter to the State Medicaid Directors on May 9, 2002 (SMDL #02-008). We further recognize that, for short hospital stays, an individual may benefit from ongoing support through the State plan HCBS benefit to meet needs not met through the provision of hospital services that are identified in the individual's person-centered service plan, to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functions. Importantly, these services must be exclusively for the benefit of the individual, not the hospital, and must not substitute for services that the hospital is obligated to provide through its conditions of participation or under federal or state laws. However, payments for room and board are expressly prohibited by section 1915(i)(1) of the Act, except for respite care furnished in a setting approved by the state that is not the individual's residence.

Section 2601 of the Affordable Care Act adds a new paragraph to section 1915(h) of the Act to permit the Secretary, at her discretion, to approve a waiver that provides medical assistance for individuals dually eligible for Medicare and Medicaid ("dual eligibles") for an initial period of up to 5 years and renewed for up to 5 years, at the state's request. The statute defines a dual eligible as: "an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance 🗋 under the state plan under this title or under a waiver of such plan." This new authority enhances existing tools available to improve and coordinate care and services for this particularly vulnerable group of beneficiaries. This change provides an important tool for states to design programs to better coordinate services for dual eligible individuals.

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Section 1902(a)(32) of the Act generally states that "no payment under the plan for care and services provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise." However, section 1902(a)(32) of the Act contains several specific exceptions to the general principle of direct payment to individual practitioners. There are exceptions for payments for practitioner services where payment is made to the employer of the practitioner, and the practitioner is required as a condition of employment to turn over fees to the employer; payments for practitioner services furnished in a facility when there is a contractual arrangement under which the facility bills on behalf of the practitioner; reassignments to a governmental agency, through a court order, or to a billing agent; payments to a practitioner whose patients were temporarily served by another identified practitioner; or payments for a childhood vaccine administered before October 1, 1994.

Section 1915(k)(1)(A)(ii) of the Act provides that home and community-based attendant services and supports must be provided in a home and community-based setting. The statute specifies that home and community-based settings do not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.[3] We are aware of settings other than those specified in section 1915(k)(1)(A)(ii) of the Act that may exhibit qualities of an institutional setting, such as public hospitals. Over the past several years, we have sought input on how to define the characteristics of what makes a setting "home and community-based" (HCB). To provide greater clarity, we are establishing with this final rule that home and community-based settings must exhibit specific qualities to be eligible sites for

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delivery of HCBS under Medicaid. Any modifications to these qualities must be justified in an individual's person-centered plan, and we believe this gives states the flexibility to address specific needs of beneficiaries. We have included these provisions to move toward a stronger articulation of the qualities that make a setting a home and truly integrated in the broader community. These are the qualities most often articulated by persons with disabilities as key determinants of independence and community integration. We believe that these qualities of home and community-based settings will support the use of the Medicaid program to maximize the opportunities for individuals to access the benefits of home and community living. We expect states electing to provide benefits under section 1915(k), 1915(i), and/or 1915(c) to include a definition of home and community-based setting that incorporates these qualities and will review all SPAs and 1915(c) waivers to determine whether they propose settings that are home or community-based. We will permit states with approved section 1915(k) SPAs, 1915(i) SPAs, and 1915(c) waivers a reasonable transition period to come into compliance with the HCB setting requirements as promulgated in our final rule.

For a detailed description of the background of this rule, please refer to "State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice" proposed rule published in the May 3, 2012 **Federal Register** (77 FR 26362 (/citation/77-FR-26362)).

B. Provisions of the Proposed Regulations and Analysis of and Responses to Public Comments

On May 3, 2012, we published a proposed rule (77 FR 26362 (/citation/77-FR-26362)) in the **Federal Register** entitled "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice," (hereinafter referred to as "HCBS proposed rule") that proposed to amend the Medicaid regulations to define and describe state plan home and community-based services (HCBS) under the Affordable Care Act. This rule offers states new flexibilities in providing necessary and appropriate services to elderly and disabled populations. The rule also proposed to amend Medicaid regulations consistent with the requirements of section 2601 of the Affordable Care Act, which added section 1915(h)(2) to the Act to provide authority for a 5-year duration for certain demonstration projects or waivers under sections 1115, 1915(b), (c), or (d) of the Act. In addition, the proposed rule includes payment reassignment provisions because states' Medicaid programs often operate as the primary or only payer for the class of practitioners that includes HCBS providers. Finally, the rule proposed Medicaid regulations to provide home and community-based setting requirements related to section 2401 of the Affordable Care Act for the section 1915(k) Community First Choice State plan option.

We received a total of 401 timely comments from state agencies, advocacy groups, health care providers, employers, health insurers, health care associations, and the general public. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding the proposed changes. We note that many expressed overall satisfaction with the benefit as a whole, in that it offers another opportunity for individuals served through the Medicaid program to return or remain in the community with family and friends. A couple stated that this opportunity offers additional flexibility and will not only provide people the opportunity to live and thrive where they choose, but also has the potential to save states' dollars.

After consideration of comments received in response to the Community First Choice (CFC) proposed rule published in the **Federal Register** on February 25, 2011, we revised the setting provision and published our proposed definition as a new proposed rule to allow for additional public comment before this final rule.

Since CFC and section 1915(i) both pertain to home and community-based services, we have aligned this CFC proposed language with the section 1915(i) proposed home and community-based setting requirements also included in this rule.

Brief summaries of each proposed provision, a summary of public comments we received (with the exception of specific comments on the paperwork burden or the economic impact analysis), and our responses to the comments follow. Comments related to the paperwork burden and the impact analyses are addressed in the "Collection of Information Requirements" and "Regulatory Impact Analysis" sections in this preamble.

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1. 5-YEAR PERIOD FOR CERTAIN DEMONSTRATION PROJECTS AND WAIVERS (PART 430)

In accordance with section 2601 of the Affordable Care Act, we proposed a 5-year approval or renewal period, subject to the discretion of the Secretary, for Medicaid waivers under sections 1915(b), 1915(c), 1915 (d) and 1115 of the Act. Specifically, this time period applies for demonstration and waiver programs through which a state serves individuals who are dually eligible for both Medicare and Medicaid benefits. While section 2601 of the Affordable Care Act did not provide a new type of waiver, it did provide an important opportunity for states to simplify the operation of existing or future waivers under current authorities that serve dually eligible individuals, especially important when states combine waiver authorities that have different approval periods. The approval of such periods is at the Secretary's discretion, and determinations will be made regarding applications for 5-year waivers in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program. We proposed that if a demonstration or waiver program does not serve or excludes dually eligible individuals, the 5-year approval period will not be available under this authority, and existing approval period requirements will apply. In addition, we proposed that in order for coverage-related waivers to be approved for 5 years periods, they must meet all necessary programmatic, financial, and quality requirements.

Comment: Commenters on this section expressed agreement with this provision. One also requested that we be mindful of the demonstrations under the Financial Alignment Initiative for dual eligibles. Another recommended clarification that this provision would also apply to other future waiver demonstration requests by states to combine Medicare and Medicaid funding at the state level for delivering care to Medicare-Medicaid eligibles.

Response: This provision is available for waivers that serve dually eligible individuals, under sections 1915 (b), 1915(c), 1915(d) and 1115 of the Act, and that meet all necessary programmatic, financial, and quality requirements.

Comment: One commenter requested that CMS make wise and appropriate use of this authority. Another commenter recommended that CMS include a statement in the regulation language like one in the preamble to the proposed rule that determinations "be made regarding applications for 5-year waivers in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program." This commenter stated that one example would be a waiver that effectively reduces services for dual eligibles, which should not be approvable as it would not be consistent with the purposes of Title XIX.

Response: We have added "and in a manner consistent with interests of the beneficiaries and the objectives of the Medicaid program" to the final regulation. In the event that the state finds a need to make reductions to its program, the state would have to explain to CMS how they will account for the interest of individuals before taking such action.

2. STATE ORGANIZATION AND GENERAL ADMINISTRATION (PART 431)

In § 431.54, we proposed to add paragraphs (a)(3) and (h) to include state plan HCBS as exceptions to comparability and community income and resource rules. For specific discussion, see the published May 3, 2012 proposed rule (77 FR 2012 (/citation/77-FR-2012) through 10385).

Comment: Commenters requested that we clarify that under section 1915(i)(3) of the Act noncompliance with comparability or community income and resource rules is optional, not mandatory. Specifically, they requested that we modify § 431.54 (a)(3) and (h) as follows:

- For § 431.54 (a)(3): Section 1915(i) of the Act provides that if a state may provide, as medical assistance, home and community-based services under an approved state plan amendment that meets certain requirements, it may elect to do so without regard to the requirements of sections 1902(a)(10)(B) and 1902(a)(10)(C)(i)(III) of the Act, with respect to such services only.
- For § 431.54(h): State plan home and community-based services. If the state so elects, the requirements of § 440.240 of this chapter related to comparability of services do not apply with respect to State plan home and community-based services defined in § 440.182 of this chapter.

Response: We believe that the language in the regulation is clear and we are finalizing the rule as proposed.

3. ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA (PART 435) AND ELIGIBILITY IN GUAM, PUERTO RICO AND THE VIRGIN ISLANDS (PART 436)

We received several comments that were in support of the eligibility policies pertaining to the new eligibility group specified at § 435.219 and § 436.219. Commenters were pleased that the regulation offers states flexibility in providing HCBS to elderly and disabled populations who do not meet an institutional level of care. Commenters were also pleased that the methodology proposed for the new eligibility group described at § 435.219(a) & (c) did not have a resource test and that the income standard for this new eligibility group is set at 150 percent of the FPL. Comments on eligibility policies not contained in this rule are not addressed.

Comment: A few commenters believed that the language in the regulation should be more detailed to better reflect the language in the preamble.

Response: We do not believe that the regulatory language should be as detailed as the language in the preamble. The language in the preamble contains the rationale for the requirements described in the regulatory language. Therefore, we are not revising the regulatory language to be as detailed as the preamble. We will be revising the regulatory language to correct an error which inaccurately indicated that a State could cover some but not all people described in paragraph (a) or (b). The response to that comment is addressed separately.

Comment: A few commenters suggested that the regulation at § 435.219(c) should be revised to include a requirement that the methodology elected by the state can be no more restrictive than the SSI methodology.

Response: To provide states with flexibility, we are not prescribing a methodology. We will review the methodology proposed by the state to determine whether it meets the criteria set forth at § 435.219(c) and § 436.219(c). We believe that the current regulatory language is in the best interest of the beneficiary.

Comment: One commenter suggested revising the introductory language in § 435.219 and § 436.219 to make it clearer that a state may choose to cover persons described in paragraph (a), persons described in paragraph (b) or both sets of persons. The commenter suggested deleting the language "any group or groups of" because the language suggests inaccurately that a state might be able to cover some but not all of the persons described in either of paragraphs (a) or (b) of the regulation.

Response: We agree with the commenter. The state has the option to provide Medicaid to individuals described in one or both of the paragraphs under (a) or (b) of this section but cannot cover some but not all of the individuals that may be eligible under either or both parts of the eligibility group. We are revising the regulatory language at § 435.219 and § 436.219 by removing the phrase "any group or groups of."

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Comment: A few commenters suggested that the language in § 453.219 should be revised to specify that any income methodologies must be applied to all members of the eligibility group.

Response: The state must use the same income methodology for all members within the eligibility group. Specifically, if a state elects to cover § 435.219(a) the income methodology must be the same for all members determined eligible under § 435.219(a). If the state elects § 435.219(b) the state must use the same income and resource methodologies and standards that it uses for the § 435.236 (the special income level) group. As described in the previous comment, states have the option to provide Medicaid to individuals described in one or both of the paragraphs under (a) or (b) of this section.

Comment: One commenter commended CMS for proposing regulations to implement optional categorical eligibility for Medicaid for individuals in need of section 1915(i) of the Act services. The commenter believes that this category has the potential to help secure coverage for uninsured and underinsured individuals and will provide states with a useful option to consolidate coverage groups.

Response: The intent of the regulation is to provide eligibility for more individuals needing State plan HCBS not to consolidate coverage groups.

Comment: One commenter urged CMS to retain the regulatory language that requires states to use income standards, which are, "reasonable, consistent with the objective of the Medicaid program . . . and in the best interest of the beneficiary.

Response: We are not changing this regulatory language, which is specified at § 435.219(c) and § 436.219(c).

4. SERVICES: GENERAL PROVISIONS (PART 440)

Section 1915(i)(1) of the Act grants states the option to provide, under the state plan, the services and supports listed in section 1915(c)(4)(B) of the Act governing HCBS waivers. The HCBS may not include payment for room and board. Eligibility for this option is based upon several different factors that are either specified by the statute or that a state may define. These include financial eligibility, the establishment of needs-based criteria, and the state option to target the benefit and to offer benefits differing in type, amount, duration or scope to specific populations. Section 1915(i) of the Act provides that State plan HCBS may be provided without determining that, but for the provision of these services, individuals would require the LOC provided in a hospital, a nursing facility (NF), or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) as is required in section 1915(c) HCBS waivers. While HCBS provided through section 1915(c) waivers must be "cost-neutral" as compared to institutional services, no cost neutrality requirement applies to the section 1915(i) State plan HCBS benefit. State plan HCBS are intended to enable individuals to receive needed services in their own homes, or in alternative living arrangements in what is collectively termed the "community" in this context.

Comment: A few commenters requested that CMS add additional services to § 440.182. One additional commenter requested that nursing services be added to the list of services specifically listed in section 1915 (c)(4)(B) of the Act governing HCBS waivers.

Response: The services that section 1915(i)(1) of the Act authorizes states to include are the services and supports listed in section 1915(c)(4)(B) of the Act governing HCBS waivers. While we are unable to expand on this list of services, we note that the "other services" specifically referenced in the statute may include coverage of services not designated in the list of specific services, and gives states the flexibility to propose and define other specific services.

Comment: Many commenters requested that CMS add to the regulation text that "other services" can include services that have been, or could be, approved as "other services" under a 1915(c) waiver and to list specific examples, such as transition services or services for individuals with traumatic brain injury.

Response: "Other services" may include coverage of services not specifically designated, and states have the flexibility to propose and define other specific services. We will provide examples of "other services" in future guidance.

Comment: A couple of commenters requested revisions to § 440.182(c) to emphasize that the habilitation services that can be covered by the state include, but are not limited to, expanded habilitation services as specified in § 440.180(c).

Response: We have revised § 440.182(c) to add the phrase "may include expanded habilitation services" to specify that states can choose whether or not to include expanded habilitation services as defined in § 440.180(c).

Comment: One commenter expressed that the final regulation regarding home and community-based settings must continue to permit the full array of home and community-based services, as defined by the Medicaid HCBS statute and regulations and included in the individual's person-centered service plan.

Response: We agree and, as in the proposed rule, the final regulation will continue to convey this flexibility for states.

Comment: Another commenter applauded the flexibility given to states to not only provide *specified* HCBS benefits under the state Plan, but to also provide other services at a state's request with Secretary approval, and encourages CMS to work with states on an ongoing basis to educate, train, and support the use of this new state plan option.

Response: We appreciate this comment and believe that this option provides states with an opportunity to deliver long-term supports and services to individuals in need. Since implementation of this benefit, we have directly and indirectly provided states with technical assistance in the use of section 1915(i) of the Act, and we are committed to continuing to offer such assistance to states.

Comment: One commenter stated that CMS should not allow section 1915(i) of the Act to be used to provide instrumental activities of daily living (IADL) services while an individual is in a general acute hospital short-term stay, as this would be duplicative to the services received in the hospital and would be hard to administer without increased costs to the state.

However, another commenter was supportive of allowing HCBS to continue, as applicable for people who are temporarily hospitalized, stating that based on the needs of the individual, there could be a genuine necessity for HCBS while an individual is hospitalized in a short-term acute care setting and would not be a duplication of hospital care services:

"Some individuals may need assistance from their personal care provider to communicate their needs, medical history, redirect behaviors, and provide consistent person-directed physical assistance. Most hospitals do not have adequate, nor trained staff to provide the level and type of ongoing 'personal care' many people using HCBS require. Providing continuation of HCBS while someone is in a hospital is not letting hospitals avoid their responsibilities, but rather acknowledging the reality that their focus/responsibility is on `medical care', while HCBS' focus is on `personal care'."

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Response: We agree with the second commenter and believe that this should remain an option afforded to the state subject to the conditions and limitations stated in our rule. To support program integrity, states are required to perform claims edits or adopt other systematic approaches that prevent duplicate payment.

Comment: One commenter noted that the inclusion of "other services" including certain transition services can make a significant difference in addressing chronic homelessness.

Response: We agree.

Comment: One commenter suggested providing FFP for rent and food expenses reasonably attributed to a related caregiver providing State plan HCBS, just as CMS proposed in the proposed rule for unrelated caregivers.

Response: Section 1915(i) of the Act does not include authority that would allow payment for the costs of rent and food attributable to a related personal caregiver residing in the same household as the participant.

Comment: One commenter asked us to clarify if there can be differences in the amount, scope or duration of services provided under 1915(i) and similarly named services provided in a section 1915(c) HCBS waiver, and whether rates or rate methodologies could differ. The commenter also asked whether there could be different provider qualifications for a covered State plan HCBS benefit and a similar covered HCBS waiver service.

Response: States are permitted the flexibility to define the section 1915(i) of the Act services they will include under their benefit, including the amount, duration, and scope of those services. If a proposed section 1915(i) service is also available under another Medicaid authority, states must explain how the section 1915(i) services would not be provided in duplicate, or incur duplicate payment. However, we note that while 1915(i) services are not identified in 1905(a) and are not part of the EPSDT requirement, all Medicaid-eligible children must have full access to services required under EPSDT, and the provision of section 1915(i) of the Act State plan HCBS should in no way hinder their access to such services.

With regard to rate methodologies, while rate determination methods may vary, payments for Medicaid services must be consistent with the provision of section 1902(a)(30)(A) of the Act (that is, "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers") and the related federal regulations at § 447.200 through 205. If the state-established rates will vary for different providers of a service (including a service that is also available under a section 1915(c) of the Act waiver), the state must explain the basis for the variation.

Provider qualifications must be reasonable and appropriate to the nature of the service, reflect sufficient training, experience and education to ensure that individuals will receive services in a safe and effective manner, and not have the effect of limiting the number of providers by the inclusion of requirements that are unrelated to quality and effectiveness. If the state-established minimum provider qualifications will vary for a service that is also available under a section 1915(c) of the Act waiver, the state must explain the basis for the variation.

Comment: One commenter requested that CMS amend the language to ensure that the rule addresses individuals with disabilities across the lifespan, including children, in order to help states understand that they can serve children under the special population classification. They expressed concern that the proposed rule does not explicitly address children. They also requested that CMS add language to specify children with physical and sensory disabilities, not just those with cognitive and behavioral disorders.

Response: Our intention was not to exclude children with disabilities or any other population as we cited examples in the preamble to the proposed rules. The regulation text does not cite specific populations who can receive Medicaid HCBS, nor do we think it prudent to do so, as it may imply limitations on state flexibility.

Comment: One commenter requested that CMS allow federal financial payment for room and board costs to be included in payment for State plan HCBS, in order to make such alternatives viable for individuals who, without housing assistance, must seek institutional placement.

Response: The statute explicitly excludes coverage of room and board and our rule cannot override that exclusion.

Comment: For § 440.182(c)(8), which refers to conditions set forth at § 440.180 for persons with chronic mental illness, one commenter proposed instead a reference to § 440.180(d)(2).

Response: We agree that this reference is more precise and have incorporated this revision.

Comment: One commenter expressed support for not including the phrase "as cost effective and necessary to avoid institutionalization," which appears in § 440.180(b)(9) to describe the "other" services that might be authorized under section 1915(c) of the Act, in § 440.182(c)(9) pertaining to section 1915(i) of the Act.

Response: We agree that this phrase is not appropriate to include in § 440.182(c)(9), as State plan HCBS under 1915(i) are not subject to cost neutrality.

Comment: One commenter indicated that the regulation text should indicate that services must be furnished to individuals with an assessed need, and must not be based on available funds.

Response: This is reflected in § 441.725(b) regarding the person-centered service plan.

Income Eligibility:

Section 1915(i)(1) of the Act requires that in order to receive State plan HCBS, individuals must be eligible for Medicaid under an eligibility group covered under the State's Medicaid plan. In determining whether either of the relevant income requirements (discussed) is met, the regular rules for determining income eligibility for the individual's eligibility group apply, including any less restrictive income rules used by the state for that group under section 1902(r)(2) of the Act.

Section 2402(b) of the Affordable Care Act added a new option at section 1915(i)(6) of the Act, to allow states, in addition to continuing to provide services to individuals described in section 1915(i)(1) of the Act, to provide section 1915(i) of the Act services to certain individuals who meet the needs-based criteria, who would be eligible for HCBS under sections 1915(c), (d) or (e) of the Act waivers or a section 1115 waiver approved for the state, and who have income up to 300 percent of the Supplemental Security Income Federal Benefit Rate (SSI/FBR).

Kennedy, Alice

From: Corjay, Matthew
Sent: Monday, October 02, 2017 3:55 PM
To: Tierney-Ward, Megan
Subject: RE: Policy and Planning Meeting

Awesome

From: Tierney-Ward, Megan
Sent: Monday, October 02, 2017 3:49 PM
To: Corjay, Matthew <Matthew.Corjay@vermont.gov>
Subject: Re: Policy and Planning Meeting

Thanks Matt! This is great.

I met with Rio last week to better understand the ILA questions and SAMS catalogues. She is going to reach out to Medicare to see if other states have already created assessments that align with the new HCBS regulations and have person-center outcomes.

I think prioritizing the ILA makes sense. Let's make that an agenda item on the next meeting and create a plan.

Megan

From: Corjay, Matthew
Sent: Monday, October 2, 2017 11:41:06 AM
To: Tierney-Ward, Megan
Subject: Policy and Planning Meeting

Megan,

Deb C, Sara, Lisa N, Paula, Mary W and myself were in attendance today. Topics discussed:

1. As we discussed some AFC and TBI subjects we realized that many of these topics could possibly change based the outcome of the meeting with You, Claire, Andre and Chris. We have postponed our AA training that we were thinking about for this fall. It seemed like we need to wait for the outcome of this meeting to understand the policy implications prior to any trainings of the authorized agencies.

2. As we were talking through other policy related issues we seemed to always come back to the fact that our current ILAs is the root cause of many of our challenges. It was the group's feeling that of all things we could

work a new ILA would have the greatest impact on our work flows and policies. I know that we have been talking about a new ILA since I have been here. What are thoughts on prioritizing the new ILA project? If you feel it is a priority, we thought that at the next meeting we could brainstorm a project outline and the barriers that we would face in taking such a project. I can facilitate the discussion but it would be critical that you were there for the discussion.

Thanks,

Matt Corjay
Project Director

Money Follows the Person
State of Vermont
Division of Disability and Aging Services
Adult Services Division

New Office Numbers Effective 02/01/2016:
Office: (802) 241-0286
Fax: (802) 241-0385

New email: matthew.corjay@vermont.gov

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Monday, October 16, 2017 1:59 PM
To: Phyllis Sisolak
Subject: RE: Question about Personalized Care Plans

That sounds good. I'm t 241-0308

From: Phyllis Sisolak [mailto:phyllis.sisolak@mediware.com]
Sent: Monday, October 16, 2017 1:18 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: Question about Personalized Care Plans

Hi Megan,

That time is fine. You want to call me at 10? I put an entry in my calendar to speak with you.

Regards,

Phyl

Phyllis B. Sisolak
Account Executive – Human and Social Services

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From: Tierney-Ward, Megan [mailto:megan.tierney-ward@vermont.gov]
Sent: Monday, October 16, 2017 1:00 PM
To: Phyllis Sisolak <phyllis.sisolak@mediware.com>
Cc: Keith Boushee <keith.boushee@mediware.com>
Subject: RE: Question about Personalized Care Plans

Thank you Phyllis. I will be in meetings the rest of the day and my next couple of days are packed. Would 10am on Thursday work for you?

M

From: Phyllis Sisolak [mailto:phyllis.sisolak@mediware.com]
Sent: Monday, October 16, 2017 10:08 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Cc: Keith Boushee <keith.boushee@mediware.com>
Subject: RE: Question about Personalized Care Plans

Hi Megan,

I would be happy to talk to you about your HCBS assessments. When you have a moment, please give me a call or send me your phone number and I'll call you!

Thank you.

Phyl

Phyllis B. Sisolak
Account Executive – Human and Social Services

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From: Keith Boushee
Sent: Friday, October 13, 2017 5:22 PM
To: Tierney-Ward, Megan (megan.tierney-ward@vermont.gov) <megan.tierney-ward@vermont.gov>
Cc: Phyllis Sisolak <phyllis.sisolak@mediware.com>
Subject: Question about Personalized Care Plans

Hi Megan,

During our onsite visit, you had brought up a question regarding what other SAMS customers might be using for personalized care plans/assessments in regards tto HCBS regulations. I'm cc'ing Phyl Sisolak on this email as a way of introducing her. She is the Mediware Account Manager for Vermont and has fielded a call from Rio Demers regarding this topic. I'm asking her to take the lead on this and contact you to complete this request. Thanks!

Keith

Keith Boushee
Regional Sales Manager/Northeast – Human & Social Services

Mediware Information Systems, Inc.
Office: (703) 657-1519 | Mobile: (860) 324-1473
www.mediware.com

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Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Thursday, January 18, 2018 11:36 AM
To: Phyllis Sisolak
Subject: RE: question for other States SAMS/Omnia users

Hi Phillis. Is there a resource where we can look at the assessment/care planning tools available from InterRai that are compatible with SAMS? And what is the best way to actually view the tools? And finally, is there a contact at InterRai that can answer questions once we've looked at the tools?

Megan

From: Tierney-Ward, Megan
Sent: Monday, November 13, 2017 12:38 PM
To: 'Phyllis Sisolak' <phyllis.sisolak@mediware.com>
Subject: RE: question for other States SAMS/Omnia users

Hi Phillis,
We reviewed the attached assessments and none of them have what we need with regards to a person-centered care plan function. Do you happen to have information about InterRai? We are interested in learning more about what they have to offer.

Also, we just learned that CMS has given out some grants to states to develop a tool. This information might be helpful to us so we are going to ask our CMS rep more about it. Here is the link that also includes a list of the participating states. Maybe some of them are SAMS/Mobile Assessment users?
https://www.medicaid.gov/medicaid/ltss/teft-program/index.html

Megan

From: Phyllis Sisolak [mailto:phyllis.sisolak@mediware.com]
Sent: Tuesday, October 24, 2017 9:23 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: question for other States SAMS/Omnia users

Hi Megan,

I got these sample assessments from another user. I'm not sure if these will be of any use to you on their own. I am meeting with a peer today to talk about InterRai which is the software that Keith mentioned while he was onsite. I'll find out more about this and see if it can meet any of your long term needs that we spoke about.

Thank you!

Phyl

Phyllis B. Sisolak
Account Executive – Human and Social Services

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From: Tierney-Ward, Megan [mailto:megan.tierney-ward@vermont.gov]
Sent: Thursday, October 19, 2017 10:26 AM
To: Phyllis Sisolak <phyllis.sisolak@mediware.com>
Subject: FW: question for other States SAMS/Omnia users

From: Tierney-Ward, Megan
Sent: Thursday, September 21, 2017 11:26 AM
To: Demers, Rio <Rio.Demers@vermont.gov>
Cc: Senghas, Stuart <Stuart.Senghas@vermont.gov>
Subject: question for other States SAMS/Omnia users

Hi Rio,
Here is the question I would like to pose to other states who use SAMS/Omnia assessments.

Vermont s interested in knowing whether other states have created the following assessment forms in SAMS:

- a needs assessment using the new HCBS regulations framework
- a person-centered care plan using the new HCBS regulations framework
- a case management monitoring tool using the new HCBS regulations framework

If so, we would love to get a PDF copy of them.

I am copying Stuart as he is leading the case management supervisors in creating the person-centered care plan.

Thanks!

Megan

Megan Tierney-Ward
Adult Services Division Director

Falls are the leading cause of fatal and non-fatal injuries among older adults, but you have the power to prevent a fall. September is ***Falls Prevention Awareness Month***! Learn more at Falls Free Vermont or by calling the Senior Helpline at 1-800-642-5119.

Falls Free
Vermont Coalition

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. Thank you.

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An official website of the United States government

Testing Experience & Functional Tools

In March 2014, the Centers for Medicare & Medicaid Services (CMS) awarded Testing Experience and Functional Tools (TEFT) grants to nine states to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (CB-LTSS). The grant program, spanning four years through March 2018, is designed to field test a cross-disability experience of care survey and a set of functional assessment items, demonstrate personal health records, and create an electronic LTSS service plan standard.

With the total grant program nearing $42 million, this is the first time CMS is promoting the use of health information technology (HIT) in CB-LTSS systems. TEFT will provide national measures and valuable feedback on how HIT can be implemented in this component of the Medicaid program.

The nine states that received initial planning grant awards were Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, Minnesota, and New Hampshire.

Four Grant Components

There are four possible TEFT components in which grantees may participate:

Experience of Care (EoC) Survey

The EoC survey elicits feedback on beneficiaries' experience with the services they receive in Medicaid CB-LTSS programs. In 2015, all nine grantee states conducted a field test of the survey with a range of CB-LTSS beneficiaries, including frail elderly, individuals with physical disabilities, persons with developmental or intellectual disabilities, those with acquired brain injury and persons with severe mental illness.

Grantees will also administer the finalized survey to their CB-LTSS beneficiaries and use the results to assess and improve quality in their programs.

- 2014-2015: Field Test
- HCBS measures are endorsed and added to settings represented in NQF (PDF 40.02 KB)
- 2015-2017: Grantees deploy finalized survey for state use
- January 2017: CAHPS® Home and Community-Based Services Survey National Training Call Part 1 & 2
  - Part 1 Research and Development of the Survey (PDF 1.96 MB) January 10, 2017 (transcript (PDF 229.52 KB))
  - Part 2 Administration and State Uses of the Survey (PDF 2.46 MB) January 24, 2017 (transcript (PDF 228.53 KB))

Functional Assessment Standardized Items (FASI)

Under prior initiatives, CMS invested in the development of standardized functional assessment items for assessing Medicare post-acute care recipients (Continunity Assessment Record and Evaluation (CARE). TEFT grantees will provide a sample of CB-LTSS beneficiaries with differing disabilities with whom the FASI items will be field tested for reliability in 2016. Following the field test, the functional assessment standardized items will be finalized and grantees will then demonstrate item use in their respective CB-LTSS programs.

- 2015 FASI Alpha Test Report (PDF 2.95 MB) January 26, 2017
- 2016: Field Test
- 2017-2018: Grantees demonstrate use of finalized LTSS FASI

Personal Health Record (PHR)

Grantees will demonstrate design, test and launch use of electronic PHR systems for beneficiaries of CB-LTSS. Information available in a PHR may assist the beneficiary, their family, and/or caregivers in making care-related decisions and encourage a more active role in managing care. A PHR has the potential to facilitate more efficient care and

HCBS CQS July 2018 000851

enhanced outcomes for beneficiaries and their families. Grantees will be working on this component of TEFT throughout the grant period.

- 2015-2018: Grantees demonstrate use of PHR

Electronic Long Term Services and Supports Standard (eLTSS)

The Office of the National Coordinator for Health Information Technology (ONC) has partnered with CMS to identify and harmonize a service plan standard to enable electronic exchange of information relevant to the care of persons receiving CB-LTSS. Grantees will pilot test an eLTSS service plan standard in conjunction with ONC's Standards and Interoperability (S&I) Framework. Additional information on these efforts can be found on ONC's S&I Framework site.

- 2015-2017: Grantees pilot eLTSS standard

The table below describes the components in which each grantee is participating:

State	
Arizona	
Test Experience of Care Survey	X
Test FASI	X
Demo PHR	
S&I Framework Participation	
# of Components	2

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State Colorado	
Test Experience of Care Survey	X
Test FASI	X
Demo PHR	X
S&I Framework Participation	X
# of Components	4
State Connecticut	
Test Experience of Care Survey	X
Test FASI	X
Demo PHR	X
S&I Framework Participation	X
# of Components	4

State Georgia	
Test Experience of Care Survey	X
Test FASI	X
Demo PHR	X
S&I Framework Participation	X
# of Components	4
State Kentucky	
Test Experience of Care Survey	X
Test FASI	X
Demo PHR	X
S&I Framework Participation	X
# of Components	4
State	

Louisiana

Test Experience of Care Survey

X

Test
FASI

Demo
PHR

S&I Framework
Participation

# of Components

1

State
Maryland

Test Experience of Care Survey

X

Test
FASI

Demo
PHR

X

S&I Framework
Participation

X

# of Components

3

State
Minnesota

Test Experience of Care Survey	X
Test FASI	X
Demo PHR	X
S&I Framework Participation	X
# of Components	4
State New Hampshire	
Test Experience of Care Survey	X
Test FASI	
Demo PHR	
S&I Framework Participation	
# of Components	1

*Louisiana participated in round one Experience of Care data collection.

Additional Information

TEFT Funding Opportunity Announcement

The TEFT funding opportunity announcement opened June 27, 2013 and closed October 3, 2013. While now closed, the Planning and Demonstration Grant for TEFT in Community-Based LTSS Funding Opportunity (PDF 1.07 MB) is available for review.

TEFT Fact Sheet

For more information on TEFT grantee technical assistance, evaluation of the TEFT Demonstration or contact information, please view the TEFT Fact Sheet (PDF 166.78 KB).

Promising Practices

During the TEFT demonstration, at least ten Promising Practice monographs are planned for release. These cover a variety of topics relevant to grantees as they progress through the demonstration.

Monographs released to date:

- Maximizing Data Quality in HCBS Experience of Care Survey Data Collection Efforts (PDF 1013.68 KB) (February 2015)
- Grantee Experience with PHR Stakeholder Engagement (PDF 435.25 KB) (June 2015)
- Vender Selection Strategies for HCBS EoC Survey (PDF 545.52 KB) (October 2015)
- Facilitating Person-Centered Health and Care Through Inclusive Design of Technology (PDF 365.85 KB) (November 2016)

Online Training Modules

At least ten technical assistance modules will be developed for the TEFT demonstration. These online recordings cover multiple demonstration-related topics for the TEFT grantees.

Online modules released to date:

- FASI Data Uses May 8, 2017

- Selecting Entities to Participate in Phase I Piloting of the eLTSS Plan July 14, 2015
- Disability Sensibility – The Diversity of Disability in the TEFT Demonstration Grant November 13, 2015
- TEFT 101 Overview October 5, 2016

TEFT Program

Related Sites

Data.Medicaid.gov

CMS.gov

HHS.gov

Healthcare.gov

InsureKidsNow.gov

Medicare.gov

Helpful Links

Site Map

Web Policies & Important Links

Privacy Policy

Plain Language

No Fear Act

Nondiscrimination & Accessibility

Archive

Help with File Formats & Plug-ins

Site Feedback

Sign up

Your email address

e-mail here

Sign up

Medicaid.gov
Keeping America Healthy

Centers for Medicare & Medicaid Services

A federal government managed website by the
Centers for Medicare & Medicaid Services.
7500 Security Boulevard Baltimore, MD 21244

Kennedy, Alice

From: Brooks, Dale
Sent: Wednesday, October 25, 2017 3:58 PM
To: Tierney-Ward, Megan
Subject: Re: random sample

Kind of... there's a few functions I can use depending what kind of sample it is... most are random but we want to think about if it is stratified or non stratiified, i.e., subpopulations, etc.... people who shouldn't be subject to sampling, etc. we can discuss more as we get closer to the selection time if you want...or anytime.

Get Outlook for iOS

From: Tierney-Ward, Megan
Sent: Wednesday, October 25, 2017 3:54:27 PM
To: Brooks, Dale
Subject: RE: random sample

Excellent! We are not ready to do it yet, but in the next month or so we should be ready. Do we just send you the list and you push a button to pull a random sample?

M

From: Brooks, Dale
Sent: Wednesday, October 25, 2017 3:51 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: Re: random sample

Yes, Megan. I can help with that.

Get Outlook for iOS

From: Tierney-Ward, Megan
Sent: Wednesday, October 25, 2017 3:48:34 PM
To: Brooks, Dale
Subject: random sample

Hi Dale,
We are about to do a consume survey for our HCBS regulations validation process. It requires that we pick a 15% random sample of consumers receiving certain CFC and TBI services. Do you have an "easy" way to pick a random sample from a list of names?

M

Megan Tierney-Ward
Adult Services Division Director

Falls are the leading cause of fatal and non-fatal injuries among older adults, but you have the power to prevent a fall. September is ***Falls Prevention Awareness Month***! Learn more at Falls Free Vermont or by calling the Senior Helpline at 1-800-642-5119.

NEW ASD Website: http://asd.vermont.gov/

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Department of Disabilities, Aging & Independent Living
Adult Services Division
280 State Drive, HC 2 South
Waterbury, VT 05671-0270
Main Phone: (802) 241-0294
Direct Line: (802) 241-0308
FAX: (802) 241-0385
megan.tierney-ward@vermont.gov

NOTE: If you need immediate assistance and are unable to reach me, please contact Colleen Bedard at colleen.bedard@vermont.gov. Thank you.

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Friday, September 01, 2017 2:18 PM
To: Demers, Rio
Subject: RE: SAMS questions catalogues

They just can't make it easy can they?

I'll set up some time for us. Thanks Rio!

From: Demers, Rio
Sent: Friday, September 01, 2017 1:58 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: SAMS questions catalogues

Looks like we might have to sit down and go through the list. Mediware only "Publishes" the questions through Omnia Designer via the Portal to those who have licenses for them.

Rio

From: Tierney-Ward, Megan
Sent: Thursday, August 31, 2017 1:45 PM
To: Demers, Rio <Rio.Demers@vermont.gov>
Subject: RE: SAMS questions catalogues

Perfect! We are exploring. Mostly interested to see if they have newer questions that would be relevant to the person-centered planning and HCBS regulations compliance.

From: Demers, Rio
Sent: Thursday, August 31, 2017 10:22 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>
Subject: RE: SAMS questions catalogues

Absolutely! There are over 3000 questions so I am not sure if you were looking for something specific? I can access them through OMNIA but let me see if Mediware has something they can send me that I can relay to you.

Rio

Rio Demers
DAIL Senior Program Consultant
Commissioner's Office
Policy, Planning and Analysis Unit
HC 2 South
280 State St
Waterbury, VT 05671-2070
Office: 802-241-0291

Cell: 802-556-2248

*Please note that I work from home Thursdays and Fridays and check my email often. If you need to contact me on those days, the best number is 802-556-2248

From: Tierney-Ward, Megan
Sent: Thursday, August 31, 2017 10:17 AM
To: Demers, Rio <Rio.Demers@vermont.gov>
Subject: SAMS questions catalogues

Hi Rio,
Is there a way to see what questions are now available in the SAMS/Mediware questions catalogues?

M

Megan Tierney-Ward
Adult Services Division Director

How hot is it today? Older Vermonters are at higher risk of health problems on hot summer days – watch this Across the Fence episode to learn more about the risks and what you can do to prevent heat illness for yourself or someone you know. For resources to beat the heat in your area, visit healthvermont.gov or call the Vermont Senior Helpline at 1-800-642-5119.

NEW ASD Website: http://asd.vermont.gov/

NEED ASSISTANCE? Dial 211

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Choices for Care: Home and Community-Based Settings, Application of Federal Rules

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	✓	✓	N/A
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	✓	✓	N/A
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	✓	✓	N/A
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	✓	✓	N/A
5. Facilitates individual choice regarding services and supports, *and who provides them*	✓	✓	N/A
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each	✓	N/A	N/A

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*			
7. Each individual has privacy in their sleeping or living unit	✓	N/A	N/A
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	✓✪	N/A	N/A
9. Individuals sharing units have a choice of roommates in that setting	✓	N/A	N/A
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	✓✪	✓	N/A
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	✓✪	✓	N/A
12. Individuals are able to have visitors of their choosing *at any time*	✓✪	✓✪	N/A
13. The setting is physically accessible to the individual	✓	✓	N/A
14. Modification to HCBS Settings Requirements	✓✪	✓✪	N/A

Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
1. Includes people chosen by the individual and led by person or legal rep where possible	✓	✓	✓
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	✓	✓	✓

Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
3. Is timely, occurs at times and locations of convenience to the individual	✓✪	✓	✓✪
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	✓	✓	✓
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	✓	✓	✓
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*	✓✪	✓✪	✓✪
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	✓	✓	✓
8. Includes a method for the individual to request updates to the plan as needed	✓	✓	✓
9. Records the alternative home- and community-based settings that were considered by the individual	✓	N/A	✓
10. Reflect that the setting in which the individual resides is chosen by the individual.	✓✪	✓	✓✪
11. Reflect the individual's strengths and preferences	✓	✓	✓
12. Reflect needs identified through functional assessments	✓	✓	✓
13. Include individually identified goals and desired outcomes	✓	✓	✓

Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	✓	✓	✓
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	✓	✓	✓
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	✓	✓	✓
17. Identify the individual and/or entity responsible for monitoring the plan	✓	✓	✓
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	✓	✓	✓
19. Be distributed to the individual and other people involved in the plan	✓	✓	✓
20. Include those services, the purpose or control of which the individual elects to self-direct	✓	✓	✓
21. Prevent the provision of unnecessary or inappropriate services and supports	✓	✓	✓
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual	✓	✓	✓
23. Modifications to the Person-Centered Plan	✓ ✪	✓ ✪	✓ ✪

Choices for Care: Application of Federal Rules

Home-Based Settings Reference Table

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	✓	✓	N/A
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	✓	✓	N/A
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	✓	✓	N/A
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	✓	✓	N/A
5. Facilitates individual choice regarding services and supports, *and who provides them*	✓	✓	N/A
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a	✓	N/A	N/A

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✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*			
7. Each individual has privacy in their sleeping or living unit	✓	N/A	N/A
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	✓✪	N/A	N/A
9. Individuals sharing units have a choice of roommates in that setting	✓	N/A	N/A
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	✓✪	N/A	N/A
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	✓✪	✓	N/A
12. Individuals are able to have visitors of their choosing *at any time*	✓✪	✓✪	N/A
13. The setting is physically accessible to the individual	✓	✓	N/A
14. Modification to HCBS Settings Requirements	✓✪	✓✪	N/A

HCBS CQS July 2018 000869

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
1. Includes people chosen by the individual and led by person or legal rep where possible	✓	✓	✓
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	✓	✓	✓
3. Is timely, occurs at times and locations of convenience to the individual	✓✪	✓	✓✪
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	✓	✓	✓
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	✓	✓	✓
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*	✓✪	✓✪	✓✪
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	✓	✓	✓
8. Includes a method for the individual to request updates to the plan as needed	✓	✓	✓
9. Records the alternative home- and community-based settings that were considered by the individual	✓	N/A	✓

HCBS CQS July 2018 000870

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
10. Reflect that the setting in which the individual resides is chosen by the individual.	✓ ✪	✓	✓ ✪
11. Reflect the individual's strengths and preferences	✓	✓	✓
12. Reflect needs identified through functional assessments	✓	✓	✓
13. Include individually identified goals and desired outcomes	✓	✓	✓
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	✓	✓	✓
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	✓	✓	✓
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	✓	✓	✓
17. Identify the individual and/or entity responsible for monitoring the plan	✓	✓	✓
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	✓	✓	✓
19. Be distributed to the individual and other people involved in the plan	✓	✓	✓
20. Include those services, the purpose or control of which the individual elects to self-direct	✓	✓	✓
21. Prevent the provision of unnecessary or inappropriate services and supports	✓	✓	✓
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or	✓	✓	✓

HCBS CQS July 2018 000871

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
at the request of the individual			
23. Modifications to the Person-Centered Plan	✓✪	✓✪	✓✪

NOTE: Per CMS Regulations 42 CFR Section 441:

(2) Home and community-based settings do not include the following:

(i) A nursing facility.

(ii) An institution for mental diseases.

(iii) An intermediate care facility for individuals with intellectual disabilities.

(iv) A hospital.

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

HCBS CQS July 2018 000872

Choices for Care: Application of Federal Rules

Home-Based Settings Reference Table

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	✓	✓	N/A
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	✓	✓	N/A
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	✓	✓	N/A
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	✓	✓	N/A
5. Facilitates individual choice regarding services and supports, *and who provides them*	✓	✓	N/A
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a	✓	N/A	N/A

HCBS CQS July 2018 000873

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*			
7. Each individual has privacy in their sleeping or living unit	✓	N/A	N/A
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	✓✪	N/A	N/A
9. Individuals sharing units have a choice of roommates in that setting	✓	N/A	N/A
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	✓✪	N/A	N/A
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	✓✪	✓	N/A
12. Individuals are able to have visitors of their choosing *at any time*	✓✪	✓✪	N/A
13. The setting is physically accessible to the individual	✓	✓	N/A
14. Modification to HCBS Settings Requirements	✓✪	✓✪	N/A

HCBS CQS July 2018 000874

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
1. Includes people chosen by the individual and led by person or legal rep where possible	✓	✓	✓
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	✓	✓	✓
3. Is timely, occurs at times and locations of convenience to the individual	✓✪	✓	✓✪
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	✓	✓	✓
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	✓	✓	✓
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*	✓✪	✓✪	✓✪
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	✓	✓	✓
8. Includes a method for the individual to request updates to the plan as needed	✓	✓	✓
9. Records the alternative home- and community-based settings that were considered by the individual	✓	N/A	✓

HCBS CQS July 2018 000875

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
10. Reflect that the setting in which the individual resides is chosen by the individual.	✓✪	✓	✓✪
11. Reflect the individual's strengths and preferences	✓	✓	✓
12. Reflect needs identified through functional assessments	✓	✓	✓
13. Include individually identified goals and desired outcomes	✓	✓	✓
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	✓	✓	✓
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	✓	✓	✓
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	✓	✓	✓
17. Identify the individual and/or entity responsible for monitoring the plan	✓	✓	✓
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	✓	✓	✓
19. Be distributed to the individual and other people involved in the plan	✓	✓	✓
20. Include those services, the purpose or control of which the individual elects to self-direct	✓	✓	✓
21. Prevent the provision of unnecessary or inappropriate services and supports	✓	✓	✓
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or	✓	✓	✓

HCBS CQS July 2018 000876

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
at the request of the individual			
23. Modifications to the Person-Centered Plan	✓✪	✓✪	✓✪

NOTE: Per CMS Regulations 42 CFR Section 441:

(2) Home and community-based settings do not include the following:
(i) A nursing facility.
(ii) An institution for mental diseases.
(iii) An intermediate care facility for individuals with intellectual disabilities.
(iv) A hospital.
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

HCBS CQS July 2018 000877

Choices for Care: Application of Federal Rules

Enhanced Residential Care (PNMI) Reference Table

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

Aligned = VT Requirements are in Alignment with Federal Regulations

✪= VT Needs to Strengthen Requirements to Align with Federal Regulations

CMS Settings Requirements	
1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	✪
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	Aligned
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	Aligned
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	Aligned
5. Facilitates individual choice regarding services and supports, *and who provides them*	Aligned
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*	Aligned
7. Each individual has privacy in their sleeping or living unit	Aligned

HCBS CQS July 2018 000878

Aligned = VT Requirements are in Alignment with Federal Regulations

✪= VT Needs to Strengthen Requirements to Align with Federal Regulations

CMS Settings Requirements	
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	✪
9. Individuals sharing units have a choice of roommates in that setting	✪
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	✪
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	✪
12. Individuals are able to have visitors of their choosing *at any time*	✪
13. The setting is physically accessible to the individual	Aligned
14. Modification to HCBS Settings Requirements	✪

Aligned = VT Requirements are in Alignment with Federal Regulations

✪= VT Needs to Strengthen Requirements to Align with Federal Regulations

CMS Person-Centered Planning Requirements	
1. Includes people chosen by the individual and led by person or legal rep where possible	Aligned
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	Aligned
3. Is timely, occurs at times and locations of convenience to the individual	✪
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	Aligned
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	Aligned

HCBS CQS July 2018 000879

Aligned = VT Requirements are in Alignment with Federal Regulations

✪= VT Needs to Strengthen Requirements to Align with Federal Regulations

CMS Person-Centered Planning Requirements	
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS*. In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process.*	✪
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	Aligned
8. Includes a method for the individual to request updates to the plan as needed	Aligned
9. Records the alternative home- and community-based settings that were considered by the individual	✪
10. Reflect that the setting in which the individual resides is chosen by the individual.	✪
11. Reflect the individual's strengths and preferences	Aligned
12. Reflect needs identified through functional assessments	Aligned
13. Include individually identified goals and desired outcomes	Aligned
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	Aligned
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	Aligned
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	Aligned
17. Identify the individual and/or entity responsible for monitoring the plan	Aligned
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	Aligned

HCBS CQS July 2018 000880

Aligned = VT Requirements are in Alignment with Federal Regulations

✪= VT Needs to Strengthen Requirements to Align with Federal Regulations

CMS Person-Centered Planning Requirements	
19. Be distributed to the individual and other people involved in the plan	Aligned
20. Include those services, the purpose or control of which the individual elects to self-direct	Aligned
21. Prevent the provision of unnecessary or inappropriate services and supports	Aligned
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual	Aligned
23. Modifications to the Person-Centered Plan	✪

NOTE: Per CMS Regulations 42 CFR Section 441:

(2) Home and community-based settings do not include the following:

(i) A nursing facility.

(ii) An institution for mental diseases.

(iii) An intermediate care facility for individuals with intellectual disabilities.

(iv) A hospital.

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

HCBS CQS July 2018 000881

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Addison						
[redacted]			Addison	365.04	Cost:	$97,367.12
			Addison	1,080.00	Cost:	$26,236.80
			Addison	80.00	Cost:	$4,000.00
			Addison	1,285.80	Cost:	$44,393.51
			Addison	2,525.04	Cost:	$80,603.58
County: Addison: 5 unduplicated consumers			Units:	5,335.88	Cost:	$252,601.01
County: Caledonia						
[redacted]			Caledonia	2,700.00	Cost:	$65,592.00
			Caledonia	1,080.00	Cost:	$26,236.80
			Caledonia	1,286.52	Cost:	$43,176.99
			Caledonia	1,140.00	Cost:	$27,501.60
			Caledonia	365.04	Cost:	$83,981.10
			Caledonia	365.04	Cost:	$73,088.31
			Caledonia	363.60	Cost:	$99,990.00

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Caledonia						
[redacted]			Caledonia			
			2,717.04	Cost:	$83,262.78	
			Caledonia			
			3,905.04	Cost:	$114,899.58	
			13,922.28	Cost:	$870,330.18	
County: Chittenden						
[redacted]			Chittenden			
			60.80	Cost:	$7,133.06	
			Chittenden			
			182.46	Cost:	$44,443.61	
			Chittenden			
			1,080.00	Cost:	$26,236.80	
			Chittenden			
			182.52	Cost:	$55,287.13	
			Chittenden			
			1,080.00	Cost:	$26,236.80	
			Chittenden			
			2,549.04	Cost:	$84,750.78	
			Chittenden			
			1,152.00	Cost:	$31,310.40	
			Chittenden			
			2,657.04	Cost:	$96,045.18	
[redacted]			Chittenden			
			364.80	Cost:	$21,888.00	
			Chittenden			
			182.46	Cost:	$33,713.13	
			Chittenden			
			1,104.00	Cost:	$30,384.00	
			Chittenden			

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Chittenden						
[redacted]			Chittenden			
			181.80	Cost:	$42,212.14	
			Chittenden			
			182.46	Cost:	$17,379.32	
			Chittenden			
			1,310.46	Cost:	$48,591.57	
			12,269.84	Cost:	$1,435,942.10	
County: Franklin						
[redacted]			Franklin			
			182.52	Cost:	$26,239.08	
			Franklin			
			365.04	Cost:	$127,764.00	
			Franklin			
			182.52	Cost:	$36,513.13	
			Franklin			
			720.00	Cost:	$22,118.40	
County: Franklin: 4 unduplicated consumers			Units:	1,450.08	Cost:	$1,648,576.70
County: Grand Isle						
[redacted]			Grand Isle			
			182.52	Cost:	$29,239.70	
			182.52	Cost:	$1,677,816.40	
County: Lamoille						
[redacted]			Lamoille			
			182.46	Cost:	$42,369.04	
			Lamoille			
			365.04	Cost:	$110,647.27	

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Lamoille						
[redacted]			Lamoille	365.04	Cost:	$101,455.57
			Lamoille	181.80	Cost:	$27,628.15
County: Lamoille: 4 unduplicated consumers			Units:	1,094.34	Cost:	$1,959,916.43
County: Orange						
[redacted]			Orange	1,418.52	Cost:	$51,250.59
			Orange	1,406.52	Cost:	$50,448.99
			Orange	1,316.52	Cost:	$45,948.99
			Orange	1,286.52	Cost:	$43,176.99
			Orange	60.00	Cost:	$3,000.00
			Orange	1,304.52	Cost:	$43,875.39
			Orange	1,273.80	Cost:	$42,319.91
County: Orange: 7 unduplicated consumers			Units:	8,066.40	Cost:	$2,239,937.29
County: Orleans						
[redacted]			Orleans	642.00	Cost:	$17,003.76
			Orleans	365.04	Cost:	$101,791.40

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Orleans						
[redacted]			Orleans			
			1,080.00	Cost:	$26,236.80	
			Orleans			
			100.00	Cost:	$5,000.00	
County: Orleans: 4 unduplicated consumers			Units:	2,187.04	Cost:	$2,389,969.25
County: Rutland						
[redacted]			Rutland			
			288.00	Cost:	$8,847.36	
			Rutland			
			2,220.00	Cost:	$55,473.60	
			Rutland			
			264.00	Cost:	$7,647.36	
			Rutland			
			780.00	Cost:	$25,118.40	
			Rutland			
			2,525.04	Cost:	$80,603.58	
			Rutland			
			1,080.00	Cost:	$26,236.80	
			Rutland			
			156.00	Cost:	$19,125.60	
			Rutland			
			1,080.00	Cost:	$26,236.80	
[redacted]			Rutland			
			1,080.00	Cost:	$26,236.80	
County: Rutland: 9 unduplicated consumers			Units:	9,473.04	Cost:	$2,665,495.56
County: Washington						
[redacted]			Washington			

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Washington						
[redacted]			Washington			
			1,274.52	Cost:	$42,375.39	
			Washington			
			182.46	Cost:	$163,838.13	
			Washington			
			1,274.52	Cost:	$42,375.39	
			Washington			
			1,486.94	Cost:	$49,437.96	
			Washington			
			182.52	Cost:	$55,323.64	
			Washington			
			1,080.00	Cost:	$26,236.80	
			Washington			
			1,273.80	Cost:	$42,319.91	
[redacted]			Washington			
			182.52	Cost:	$50,780.71	
			Washington			
			182.40	Cost:	$30,282.05	
			Washington			
			1,274.52	Cost:	$42,375.39	
			Washington			
			121.60	Cost:	$12,099.20	
			Washington			
			1,500.87	Cost:	$51,851.76	
			Washington			
			2,549.04	Cost:	$84,750.78	
			Washington			

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Washington						
[redacted]			Washington			
			1,256.52	Cost:	$41,676.99	
			Washington			
			365.04	Cost:	$65,148.69	
			Washington			
			1,080.00	Cost:	$26,236.80	
			Washington			
			1,080.00	Cost:	$26,236.80	
			Washington			
			363.60	Cost:	$102,844.26	
County: Washington: 18 unduplicated consumers			Units:	16,710.87	Cost:	$3,621,686.21
County: Windham						
[redacted]			Windham			
			1,486.87	Cost:	$49,432.56	
			Windham			
			182.52	Cost:	$37,334.47	
			Windham			
			876.00	Cost:	$21,936.48	
County: Windham: 3 unduplicated consumers			Units:	2,545.39	Cost:	$3,730,389.72
County: Windsor						
[redacted]			Windsor			
			1,092.00	Cost:	$28,310.40	
			Windsor			
			1,080.00	Cost:	$26,236.80	
			Windsor			
			181.80	Cost:	$27,628.15	
			Windsor			

Care Plan Monitoring Report

- Care Plan Monitoring Report

Full Name	Gender	Primary Phone	Town of Residence	County		
County: Windsor						
[redacted]			Windsor			
			1,274.52	Cost:	$42,375.39	
			Windsor			
			1,176.00	Cost:	$28,260.48	
			Windsor			
			364.92	Cost:	$118,496.82	
			Windsor			
			1,224.00	Cost:	$36,384.00	
County: Windsor: 7 unduplicated consumers			Units:	6,393.24	Cost:	$4,038,081.76

Summary:	85 consumers	Total Units:	79,630.92	Total :	$4,038,081.76

Care Plan Monitoring Report

- TBI Validation Survey Sample sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Choice TBI Support services			
[redacted]			Orleans
			Washington
			Washington
			Windsor
			Orange
			Washington
			Washington
			Windham
			Washington
			Grand Isle
			Washington
			Chittenden
			Washington
			Chittenden
			Washington
			Washington
			Franklin
			Chittenden
			Rutland
			Windsor
			Addison
[redacted]			Rutland
			Orange
			Windsor
			Orange

Agency: Choice TBI Support services: 25 unduplicated consumers

Agency: Eagle Eye Farm	
[redacted]	Caledonia
	Orleans
	Caledonia
	Caledonia

Agency: Eagle Eye Farm: 4 unduplicated consumers

Agency: Green Mountain Support Services, Inc.	
[redacted]	Lamoille
	Chittenden
	Caledonia
	Chittenden
	Washington
	Caledonia

Care Plan Monitoring Report

- TBI Validation Survey Sample sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: Green Mountain Support Services, Inc.			
[redacted]		Lamoille	
		Lamoille	
		Franklin	

Agency: Green Mountain Support Services, Inc.: 9 unduplicated consumers

Agency: Head Injury & Stroke Independence Project			
[redacted]		Rutland	
		Rutland	
		Rutland	
		Rutland	
		Rutland	
		Rutland	
		Rutland	

Agency: Head Injury & Stroke Independence Project: 7 unduplicated consumers

Agency: Health Care and Rehabilitation Services of SE VT			
[redacted]		Windsor	
		Windsor	

Agency: Health Care and Rehabilitation Services of SE VT: 2 unduplicated consumers

Agency: Northwestern Counseling and Support Services			
[redacted]		Chittenden	
		Franklin	
		Franklin	
		Franklin	

Agency: Northwestern Counseling and Support Services: 4 unduplicated consumers

Agency: PRIDE Inc			
[redacted]		Lamoille	
		Washington	
		Orange	
		Chittenden	
		Addison	
		Washington	
		Windsor	
		Chittenden	
		Caledonia	
		Orange	
		Chittenden	
		Orange	

Care Plan Monitoring Report

- TBI Validation Survey Sample sorted by Provider

Full Name	Primary Phone	Town of Residence	County
Agency: PRIDE Inc			
[redacted]			Washington
			Chittenden
			Washington
			Chittenden
			Chittenden
			Caledonia
			Orleans
			Windsor
			Washington
			Chittenden
			Caledonia
			Washington
			Washington
			Washington
			Addison
			Orleans

Agency: PRIDE Inc: 28 unduplicated consumers

Summary:	79 consumers

Total : $498,984.16

Kennedy, Alice

From: Lane, Sara
Sent: Wednesday, January 10, 2018 8:40 AM
To: McMann, Angela; Tierney-Ward, Megan; Corjay, Matthew
Cc: Courcelle, Andre
Subject: Thoughts about Case Management Services

Hi All-

A number of us have had side conversations about our current CFC case management agencies and the difference between the case management that happens for CFC participants versus participants being served by a TBI provider or DA/SSA for AFC. The latter having a much more person centered approach and broader responsibilities.

Given the nature of the HCBS regulations, worry about conflict of interest, as well as the desire to provide services for people with brain injury under the CFC umbrella, do we think the timing may be right (2018-2019) to do an RFP, or whatever process we need to follow, to discover if other agencies would/could become CFC case management agencies for folks enrolled in home based services?

This would create more choice and also provide case management services by "specialty" e.g. if an individual has a brain injury or mental health needs, perhaps they would choose a TBI provider or DA/SSA to provide case management. With this expertise, theoretically their needs may be met in a more efficient manner and not as much case management time would be needed. This would be budget neutral and/or potentially in some cases creating a cost savings?

I would also see this as opportunity to forge more partnership between the existing agencies if they were all wanting to provide a case management service for CFC. This would definitely benefit each community.

I believe some of the lessons learned from the MFP experience fall into the "broader approach" to case management like what the AFC agencies already provide, so this could also be the opportunity to further develop the case management standards prior to bringing on additional agencies.

When are we going to get a project manager? ☺ Ha!

Thanks,
Sara

Sara Lane, BSN, RN
Quality Management Nurse
TBI/CFC Programs
DAIL- Adult Services Division
HC2 South 280 State Drive
Waterbury, VT 05671-2070
Phone: 802.241.0299
Fax: 802.241.0385
http://asd.vermont.gov/help

Traumatic Brain Injury Service Providers Contact Information

- Addison County Home Health and Hospice (Middlebury)
  💻 Online at http://www.achhh.org/

- Bayada Home Health Care (Statewide)
  💻 Online at http://www.bayada.com/

- Caledonia Home Health Care (St. Johnsbury)
  💻 Online at http://www.nchcvt.org/services/home-carehospice/

- Central Vermont Home Health and Hospice (Barre)
  💻 Online at http://www.cvhhh.org/

- CHOICE Brain Injury Support Services (Montpelier)
  💻 Online at http://www.choicetbisupportservices.com/

- Community Associates/Counseling Service of Addison County (Middlebury)
  💻 Online at http://www.csac-vt.org/index.php?option=com_content&view=article&id=11&Itemid=26

- Eagle Eye Farm, Inc. (Northeast Kingdom)
  💻 Online at http://eagleeyefarm.info/

- Green Mountain Support Services (Morrisville)
  💻 Online at http://gmssi.com/

- Head Injury Stroke Independence Project (no website) (Rutland)
  ☎ **CONTACT** 1-802-353-8850

- Health Care and Rehabilitative Services (Springfield)
  💻 Online at http://www.hcrs.org/

- Lamoille County Home Health and Hospice (Morrisville)
  💻 Online at http://www.lhha.org/

- Manchester Health Services (Manchester Center)
  💻 Online at http://www.manchesterhealthservices.com/

- Northwestern Counseling and Support Services (St. Albans)
  💻 Online at http://www.ncssinc.org/

- Orleans/Essex VNA and Hospice (Newport)
  💻 Online at http://www.orleansessexvna.org/

- PRIDE Inc (Barre)
  💻 Online at http://www.pridetbi.com/home

- Riverview Life Skills Center (Jeffersonville)
  Online at http://www.riverviewlifeskillscenter.com/

- Rutland Area VNA and Hospice (Rutland, Bennington, Dorset)
  Online at http://www.ravnah.org/

- Rutland Mental Health Services (Rutland)
  Online at http://www.rmhsccn.org/

- United Counseling Services (Bennington)
  Online at http://www.ucsvt.org/

- VNA and Hospice of Vermont and New Hampshire (Bellows.Falls)
  Online at http://www.vnhcare.org/

- VNA of Chittenden/Grand Isle (Colchester)
  Online at http://www.vnacares.org/

- Washington County Mental Health Services, Inc. (Barre)
  Online at https://www.wcmhs.org/

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- Lamoille County Home Health and Hospice (Morrisville)
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- Manchester Health Services (Manchester Center)
  💻 Online at http://www.manchesterhealthservices.com/

- Northwestern Counseling and Support Services (St. Albans)
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- Orleans/Essex VNA and Hospice (Newport)
  💻 Online at http://www.orleansessexvna.org/

- PRIDE Inc (Barre)

💻 Online at http://www.pridetbi.com/home

- Riverview Life Skills Center (Jeffersonville)
  💻 Online at http://www.riverviewlifeskillscenter.com/

- Rutland Area VNA and Hospice (Rutland, Bennington, Dorset)
  💻 Online at http://www.ravnah.org/

- Rutland Mental Health Services (Rutland)
  💻 Online at http://www.rmhsccn.org/

- United Counseling Services (Bennington)
  💻 Online at http://www.ucsvt.org/

- VNA and Hospice of Vermont and New Hampshire (Bellows Falls)
  💻 Online at http://www.vnhcare.org/

- VNA of Chittenden/Grand Isle (Colchester)
  💻 Online at http://www.vnacares.org/

- Washington County Mental Health Services, Inc. (Barre)
  💻 Online at https://www.wcmhs.org/

Kennedy, Alice

Sent: Monday, October 02, 2017 9:23 AM
To: AHS - DAIL ASD

[redacted]

[redacted]

Quality Management Unit:

[redacted]

- Working with CFC case management supervisors to develop a universal care plan tool that complies with the new HCBS regulations.

[redacted]

Vermont is a small rural state. The State maintains a geographically designated Home Health Agency (HHA) system. Twelve HHAs are recognized in State law/regulation and are required to serve Choices for Care program participants in their region. One agency is recognized for statewide delivery of services. All designated Home Health Agencies must follow both the Medicare regulations for home health services in addition to the Vermont Regulations for the Designation and Operation of Home Health Agencies.

In addition, through the Older Americans Act (OAA), DAIL designates five regionally based Area Agencies on Aging responsible for statewide coverage of OAA services. These AAA organizations are also authorized to provide HCBS companion services under CFC. Vermont has received federal approval under the Older Americans Act State Plan to allow AAAs to provide both case management and direct care when needed to assure access to necessary services for participants.

Given the rural nature of the State and its small size, no Vermont provider only offers case management services. Due to Vermont's labor market, small population and economic drivers, developing additional provider types has not been economically viable or supported by legislative action. It is not unusual to have multiple community agencies involved with any given CFC participant.

The Vermont Department of Disabilities Aging and Independent Living (DAIL) conducts periodic on-site quality reviews and certifications of providers designated to provide case management services in the CFC program. Both HHAs and AAAs undergo certification. In the event that a consumer chooses a case manager who is also affiliated with the provision of one or more services in their care plan, Vermont standards and policies require that providers must have policies in place to address conflict of interest; individual treatment team conflicts must be considered and mitigated. In several regions, HHAs have chosen to create separate entities with differing supervisory structures to preserve a distinction between case management and direct care staff. Vermont standards are currently under review as part of our HCBS Quality Strategy and will be enhanced based on stakeholder input. A link to our current standards is available at Case Management Standards.

All Choices for Care participants have access to the State Long-Term Care Ombudsman to help resolve provider complaints, regardless of whether they receive their services in a facility or home and community setting. In addition, the State maintains a grievance and appeal system and supports Aging and Disability Resource Centers (ADRCs) in each region.

Below is a geographic table of home health and area agency on aging territories across 13 counties and 387 towns:

County	Town	Home Health Agency	Area Agency on Aging
Addison	Addison	Addison County Home Health & Hospice	Age Well
Addison	Bridport	Addison County Home Health & Hospice	Age Well
Addison	Bristol	Addison County Home Health & Hospice	Age Well
Addison	Cornwall	Addison County Home Health & Hospice	Age Well
Addison	East Middlebury	Addison County Home Health & Hospice	Age Well

Addison	Ferrisburg	Addison County Home Health & Hospice	Age Well
Addison	Goshen	Addison County Home Health & Hospice	Age Well
Addison	Leicester	Addison County Home Health & Hospice	Age Well
Addison	Lincoln	Addison County Home Health & Hospice	Age Well
Addison	Middlebury	Addison County Home Health & Hospice	Age Well
Addison	Monkton	Addison County Home Health & Hospice	Age Well
Addison	New Haven	Addison County Home Health & Hospice	Age Well
Addison	North Ferrisburg	Addison County Home Health & Hospice	Age Well
Addison	Orwell	Addison County Home Health & Hospice	Age Well
Addison	Panton	Addison County Home Health & Hospice	Age Well
Addison	Ripton	Addison County Home Health & Hospice	Age Well
Addison	Salisbury	Addison County Home Health & Hospice	Age Well
Addison	Shoreham	Addison County Home Health & Hospice	Age Well
Addison	Starksboro	Addison County Home Health & Hospice	Age Well
Addison	Vergennes	Addison County Home Health & Hospice	Age Well
Addison	Waltham	Addison County Home Health & Hospice	Age Well
Addison	Weybridge	Addison County Home Health & Hospice	Age Well
Addison	Whiting	Addison County Home Health & Hospice	Age Well
Addison	East Granville	VNA of Vermont and New Hampshire	Central VT Council on Aging
Addison	Granville	VNA of Vermont and New Hampshire	Central VT Council on Aging
Addison	Hancock	VNA of Vermont and New Hampshire	Central VT Council on Aging
Bennington	Arlington	Manchester Health Services	Southwestern VT Council on Aging

Bennington	East Arlington	Manchester Health Services	Southwestern VT Council on Aging
Bennington	Manchester	Manchester Health Services	Southwestern VT Council on Aging
Bennington	Manchester Center	Manchester Health Services	Southwestern VT Council on Aging
Bennington	Sandgate	Manchester Health Services	Southwestern VT Council on Aging
Bennington	Bennington	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Dorset	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	East Dorset	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Glastenbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	North Bennington	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	North Pownal	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Pownal	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Rupert	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Shaftsbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Sunderland	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	West Rupert	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Woodford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bennington	Landgrove	VNA of Vermont and New Hampshire	Senior Solutions
Bennington	Peru	VNA of Vermont and New Hampshire	Senior Solutions
Bennington	Readsboro	VNA of Vermont and New Hampshire	Senior Solutions
Bennington	Searsburg	VNA of Vermont and New Hampshire	Senior Solutions
Bennington	Stamford	VNA of Vermont and New Hampshire	Senior Solutions
Bennington	Winhall	VNA of Vermont and New Hampshire	Senior Solutions

Caledonia	Barnet	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Burke	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Danville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	East Burke	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	East Concord	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	East Hardwick	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	East Ryegate	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	East St. Johnsbury	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Groton	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Hardwick	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Kirby	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Lyndon	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Lyndon Center	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Lyndonville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	McIndoe Falls	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Newark	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	North Concord	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Passumpsic	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Peacham	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Ryegate	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Sheffield	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	South Ryegate	Caledonia Home Health Care	Northeastern VT Area Agency on Aging

Caledonia	St Johnsbury	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	St. Johnsbury Center	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Stannard	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Sutton	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Walden	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Waterford	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	West Barnet	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	West Burke	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	West Danville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	West Stewartsville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Caledonia	Wheelock	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Chittenden	Bolton	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Buels Gore	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Burlington	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Charlotte	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Colchester	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Essex	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Essex Junction	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Hanksville	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Hinesburg	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Huntington	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Jericho	VNA of Chittenden and Grand Isle Counties	Age Well

Chittenden	Jonesville	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Milton	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Richmond	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Shelburne	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	South Burlington	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	St George	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Underhill	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Underhill Center	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Westford	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Williston	VNA of Chittenden and Grand Isle Counties	Age Well
Chittenden	Winooski	VNA of Chittenden and Grand Isle Counties	Age Well
Essex	Concord	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	East Haven	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Gilman	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Granby	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Guildhall	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Lunenburg	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Maidstone	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Victory	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Essex	Averill	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Avery's Gore	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Beecher Falls	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging

Essex	Bloomfield	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Brighton	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Brunswick	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Canaan	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Ferdinand	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Island Pond	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Lemington	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Lewis	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Essex	Norton	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Franklin	Bakersfield	Franklin County Home Health & Hospice	Age Well
Franklin	Berkshire	Franklin County Home Health & Hospice	Age Well
Franklin	East Berkshire	Franklin County Home Health & Hospice	Age Well
Franklin	East Fairfield	Franklin County Home Health & Hospice	Age Well
Franklin	Enosburg	Franklin County Home Health & Hospice	Age Well
Franklin	Fairfax	Franklin County Home Health & Hospice	Age Well
Franklin	Fairfield	Franklin County Home Health & Hospice	Age Well
Franklin	Fletcher	Franklin County Home Health & Hospice	Age Well
Franklin	Franklin	Franklin County Home Health & Hospice	Age Well
Franklin	Georgia	Franklin County Home Health & Hospice	Age Well
Franklin	Highgate	Franklin County Home Health & Hospice	Age Well
Franklin	Highgate Springs	Franklin County Home Health & Hospice	Age Well
Franklin	Montgomery	Franklin County Home Health & Hospice	Age Well

Franklin	Montgomery Center	Franklin County Home Health & Hospice	Age Well
Franklin	Richford	Franklin County Home Health & Hospice	Age Well
Franklin	Sheldon	Franklin County Home Health & Hospice	Age Well
Franklin	Sheldon Springs	Franklin County Home Health & Hospice	Age Well
Franklin	St Albans Bay	Franklin County Home Health & Hospice	Age Well
Franklin	St Albans Town	Franklin County Home Health & Hospice	Age Well
Franklin	Swanton	Franklin County Home Health & Hospice	Age Well
Grand Isle	Alburg	VNA of Chittenden and Grand Isle Counties	Age Well
Grand Isle	Grand Isle	VNA of Chittenden and Grand Isle Counties	Age Well
Grand Isle	Isle LaMotte	VNA of Chittenden and Grand Isle Counties	Age Well
Grand Isle	North Hero	VNA of Chittenden and Grand Isle Counties	Age Well
Grand Isle	South Hero	VNA of Chittenden and Grand Isle Counties	Age Well
Lamoille	Belvidere	Lamoille Home Health	Central VT Council on Aging
Lamoille	Cambridge	Lamoille Home Health	Central VT Council on Aging
Lamoille	Eden	Lamoille Home Health	Central VT Council on Aging
Lamoille	Elmore	Lamoille Home Health	Central VT Council on Aging
Lamoille	Hyde Park	Lamoille Home Health	Central VT Council on Aging
Lamoille	Jeffersonville	Lamoille Home Health	Central VT Council on Aging
Lamoille	Johnson	Lamoille Home Health	Central VT Council on Aging
Lamoille	Morristown	Lamoille Home Health	Central VT Council on Aging
Lamoille	Morrisville	Lamoille Home Health	Central VT Council on Aging
Lamoille	Moscow	Lamoille Home Health	Central VT Council on Aging

Lamoille	North Hyde Park	Lamoille Home Health	Central VT Council on Aging
Lamoille	Stowe	Lamoille Home Health	Central VT Council on Aging
Lamoille	Waterville	Lamoille Home Health	Central VT Council on Aging
Lamoille	Wolcott	Lamoille Home Health	Central VT Council on Aging
Orange	Orange	Central VT Home Health & Hospice	Central VT Council on Aging
Orange	Washington	Central VT Home Health & Hospice	Central VT Council on Aging
Orange	Williamstown	Central VT Home Health & Hospice	Central VT Council on Aging
Orange	Bradford	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Braintree	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Brookfield	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Chelsea	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Corinth	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	East Barnard	VNA of Vermont and New Hampshire	Senior Solutions
Orange	East Corinth	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	East Randolph	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	East Thetford	VNA of Vermont and New Hampshire	Senior Solutions
Orange	Ely	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Fairlee	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Newbury	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	North Thetford	VNA of Vermont and New Hampshire	Senior Solutions
Orange	Post Mills	VNA of Vermont and New Hampshire	Senior Solutions
Orange	Randolph	VNA of Vermont and New Hampshire	Central VT Council on Aging

Orange	Randolph Center	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	South Strafford	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	South Tunbridge	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Strafford	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Thetford	VNA of Vermont and New Hampshire	Senior Solutions
Orange	Thetford Center	VNA of Vermont and New Hampshire	Senior Solutions
Orange	Topsham	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Tunbridge	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Vershire	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	Wells River	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	West Fairlee	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	West Newbury	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orange	West Topsham	VNA of Vermont and New Hampshire	Central VT Council on Aging
Orleans	Greensboro	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Orleans	Lower Waterford	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Orleans	Albany	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Barton	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Beebe Plain	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Brownington	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Charleston	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Coventry	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Craftsbury	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging

Orleans	Craftsbury Common	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Derby	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Derby Line	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	East Charleston	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Glover	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Greensboro Bend	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Holland	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Irasburg	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Jay	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Lowell	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Morgan	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Morgan Center	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Newport	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Newport Center	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	North Troy	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Orleans	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Troy	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Warners Grant	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Warrens Gore	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	West Charleston	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	West Glover	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Westfield	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging

Orleans	Westmore	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Rutland	Belmont	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Benson	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Bomoseen	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Brandon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Castleton	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Center Rutland	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Chittenden	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Clarendon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Clarendon Springs	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	ColeBrook	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Cutlingsville	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Danby	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	East Wallingford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Fair Haven	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Florence	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Forest Dale	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Hubbardton	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Hydeville	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Ira	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Mendon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Middletown Sprg	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging

Rutland	Mount Holly	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Mount Tabor	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	North Chittenden	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	North Clarendon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Pawlet	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Pittsford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Poultney	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Proctor	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Rutland City	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Rutland Town	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Shrewsbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Sudbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Tinmouth	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Wallingford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Wells	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	West Haven	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	West Pawlet	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	West Rutland	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland	Killington	VNA of Vermont and New Hampshire	Southwestern VT Council on Aging
Rutland	Pittsfield	VNA of Vermont and New Hampshire	Senior Solutions
Rutland	Sherburne	VNA of Vermont and New Hampshire	Southwestern VT Council on Aging
Statewide	Statewide	Bayada	NA

Washington	Adamant	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Barre	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Barre Town	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Berlin	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Cabot	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Calais	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Duxbury	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	East Barre	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	East Calais	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	East Montpelier	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Fayston	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Graniteville	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Marshfield	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Middlesex	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Montpelier	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Moretown	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	North Montpelier	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Northfield	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Northfield Falls	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Plainfield	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Riverton	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Roxbury	Central VT Home Health & Hospice	Central VT Council on Aging

Washington	South Barre	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Waitsfield	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Warren	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Waterbury	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Waterbury Center	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Websterville	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Woodbury	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Worcester	Central VT Home Health & Hospice	Central VT Council on Aging
Windham	Athens	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Bartonsville	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Bellows Falls	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Brattleboro	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Brockway Mills	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Brookline	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Cambridge Port	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Dover	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Dummerston	VNA of Vermont and New Hampshire	Senior Solutions
Windham	East Dover	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Grafton	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Guilford	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Halifax	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Jacksonville	VNA of Vermont and New Hampshire	Senior Solutions

Windham	Jacksonville	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Jamaica	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Londonderry	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Marlboro	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Newfane	VNA of Vermont and New Hampshire	Senior Solutions
Windham	North Westminster	VNA of Vermont and New Hampshire	Senior Solutions
Windham	North Windham	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Pikes Falls	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Putney	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Rawsonville	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Rockingham	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Saxtons River	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Somerset	VNA of Vermont and New Hampshire	Senior Solutions
Windham	South Londonderry	VNA of Vermont and New Hampshire	Senior Solutions
Windham	South Newfane	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Stratton	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Townshend	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Vernon	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Wardsboro	VNA of Vermont and New Hampshire	Senior Solutions
Windham	West Dover	VNA of Vermont and New Hampshire	Senior Solutions
Windham	West Dummerston	VNA of Vermont and New Hampshire	Senior Solutions
Windham	West Townshend	VNA of Vermont and New Hampshire	Senior Solutions

Windham	West Wardsboro	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Westminster	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Westminster Station	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Westminster West	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Whitingham	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Williamsville	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Wilmington	VNA of Vermont and New Hampshire	Senior Solutions
Windham	Windham	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Andover	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Ascutney	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Baltimore	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Barnard	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Bethel	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	Bridgewater	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Bridgewater Corners	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Brownsville	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Cavendish	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Chester	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Chester Depot	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Gaysville	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	Hartford	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Hartland	VNA of Vermont and New Hampshire	Senior Solutions

Windsor	Hartland Four Corner	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Ludlow	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	North Hartland	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	North Springfield	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	North Stratford	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Norwich	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Perkinsville	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Plymouth	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Pomfret	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Proctorsville	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Quechee	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Reading	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Rochester	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	Royalton	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	Sharon	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	South Pomfret	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	South Reading	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	South Royalton	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	South Woodstock	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Springfield	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Stockbridge	VNA of Vermont and New Hampshire	Central VT Council on Aging
Windsor	Taftsville	VNA of Vermont and New Hampshire	Senior Solutions

Windsor	Tyson	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Weathersfield	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	West Hartford	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	West Windsor	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Weston	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	White River Jct	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Wilder	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Windsor	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	Woodstock	VNA of Vermont and New Hampshire	Senior Solutions

VERMONT

Case Management Standards & Certification Procedures

Older Americans Act & Choices for Care Programs

Revised January 1, 2017

State of Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
Adult Services Division
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Available in alternative format by request.

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I. INTRODUCTION

The Adult Services Division (ASD) within the Department of Disabilities, Aging and Independent Living (DAIL) recognizes that quality case management is a critical part of our long-term services and supports system and is crucial to the fulfillment of DAIL's mission. The mission of DAIL is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.

In order to ensure the statewide quality of case management services offered under Older Americans Act (OAA) programs and Choices for Care (CFC), ASD has instituted Case Management Standards and Certification Procedures. The purpose of this document is to establish minimum case management performance standards and to provide guidance for case management agencies and individual case managers. These standards and certification procedures apply to case management services offered under OAA programs and CFC. The Choices for Care Program Manual and Regulations provide more detailed policies and procedures specific to CFC.

DAIL authority to establish service standards and to certify providers of case management services under OAA programs and CFC is established in Vermont state statute, the Center for Medicare and Medicaid Services (CMS) approved Global Commitment to Health 1115 Waiver, and the Older Americans Act.

II. DEFINITIONS

A. **Case Management:** Case management is a professional service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes.

B. **Conflict of Interest:** Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of case management services must maintain a conflict of interest policy that is in line with the standards set by the Centers for Medicare and Medicaid (CMS). See Appendix A for a link to the CMS regulations.

C. **Home and Community-Based Services (HCBS):** HCBS services are person-centered services provided to an individual in their own home or in the home of another person. HCBS services assist individuals to maintain as much independence, community participation, freedom of choice and control over their lives as possible, while preventing the need to live in a licensed facility. The Centers for Medicare and Medicaid Services (CMS) regulates Medicaid funded HCBS services with regards to person-centered planning and settings characteristics.

D. **Modifications:** "Modifications" are any individual-specific exception to the person-centered planning process as required by the federal home and community-based services (HCBS) regulations. Modifications must be documented and include specific elements identified in Section IV. M.

E. **Person Centered Planning:** Person-centered planning is a process for supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning for HCBS services covered under Vermont's Choices for Care program and other similar HCBS long-term services and supports programs. See Appendix A for a link to the CMS regulations.

F. **Quality Management:** Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 124 and

the Vermont Government Accountability Office provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.

G. **Self-Neglect:** Self-neglect is an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs. This definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision (National Adult Protective Services Association).

III. AGENCY CASE MANAGEMENT STANDARDS

All agency policies governing case management activities under OAA and CFC programs listed in the section must be reviewed and approved by ASD.Changes made to the approved policies must be reviewed and approved by ASD prior to implementation.

Case management agencies are expected to be knowledgeable of and in compliance with all relevant state and federal laws and requirements. Case management agencies shall also ensure the requisite case management agency policies are in place, the case management agency is responsible to ensure that all case managers providing services under OAA and CFC programs comply with the ASD Case Management Standards & Certification Procedures and related case management agency policies.

Case management agencies shall have the following written policies and protocols:

A. **After Hour Coverage**: The protocol shall at a minimum ensure that people are able to leave a message with the agency when it is closed.

B. **Consumer Complaint and Grievance Policy**: The policies and procedures shall outline how the case management agency will respond to consumer complaints and grievances. The policies shall address how consumers are informed about agency policies, including the complaint and grievance policy, and will explain how the process works.

C. **Information and Referral Policy**: The policy shall state that the case management agency will accept and respond to requests for information and/or assistance from individuals, caregivers and other third parties.

D. **Mandated Reporting of Abuse, Neglect, and Exploitation Policy**: The policy shall address how the case management agency will respond in cases of suspected abuse, neglect, and/or exploitation of vulnerable adults. The policy must be consistent with the requirements of Vermont statute 33 V.S.A. § 6903 and DAIL policies. ASD shall coordinate review and approval of this policy with Vermont Adult Protective Services, at the Department's Division of Licensing & Protection.

E. **Self-Neglect Policy**: The policy shall define how the agency will serve adults identified as self-neglect. This may include a referral to the AAA (for adults age 60 and older) or the local Designated Agency (DA) for adult mental health services (for adults under the age of 60). In the case of CFC referrals, the case management agency selected by the person shall be responsible for serving the person identified as self-neglecting.

F. **Maximum Caseload Policy**: The policy shall state the maximum caseload size for case managers, the prioritization process for people accessing case management services, and the management of waiting lists for people who cannot be served at any given time.

G. **Case Management Supervision Policy**: The policy shall address how supervision is provided including accessibility of supervisors, review of client records, on-going feedback between the supervisor and case manager and timely performance evaluations of case managers.

H. **Orientation Training Policy**: The policy shall outline the orientation training for new case management staff.

I. **Training Policy**: The policy shall outline ongoing case management training designed to ensure that case managers will have the necessary range of knowledge, skills and abilities to provide high quality case management services.

J. **Quality Management Policy**: The policy shall outline the case management agency's ongoing Quality Management plan regarding case management services. (Refer to Section II. Definitions for a definition of Quality Management).

K. **Conflict of Interest Policy**: At a minimum, the policy shall: (Refer to Section II. Definitions for a definition of Conflict of Interest).
   1. Define conflict of interest,
   2. Describe the agency's process for preventing conflict of interest,
   3. Describe how case managers report potential conflicts of interest immediately with their supervisor,
   4. Describe the agency's process for correcting conflict of interest when it occurs.
   5. Describe that the case manager developing the person-centered plan shall not be any of the following:
      a. Related by blood or marriage to the individual or to the paid caregivers of the individual
      b. Financially responsible for the individual
      c. Empowered to make financial or health-related decision on behalf of the individual
      d. Holding financial interest in an entity that is paid to provide care for the individual
      e. Other limitations as set by CMS and in line with federal rules.

L. **Client Record Policy**: The policy shall include:
   1. The procedure governing their use, storage and removal.
   2. The conditions for release of information contained in the record.
   3. The requirements of authorization in writing by the person or legal representative for release of information.
   4. The maintenance of all records relating to the delivery and documentation of case management services for a minimum of 3 years and the maintenance of all financial records for a period of 7 years.
   5. Compliance with the Health Insurance Portability and Accountability Act.

M. **Background Check Policy**: The policy shall outline the background checks required in order for a person to be employed as a case manager. The policy must be

consistent with the DAIL Background Check Policy.

N. **Emergency Management Plan**: The agency shall have a plan describing how it will identify the critical functions and services it performs that must continue in the event of an emergency and include a plan as to how those functions and services will be provided during that time. The plan shall describe how the agency will collaborate and cooperate with local emergency planners and other local providers. The plan shall also describe how the agency will:

1. Identify persons who might require specific assistance during an emergency; and

2. Provide information and encourage people to develop a personal emergency preparedness plan. Provide assistance in developing the plan as necessary for needed assistance and support in the event of a natural or other emergency which may result in disruption of service

   and/or personal harm. Involvement and consideration of family caregivers, as well as other natural supports must be part of the process.

O. **Agency Confidentiality Policy**: The agency shall have a policy that is no less stringent than the Agency of Human Service Consumer Information and Privacy Rule.

P. **Smoking Policy**: Agency shall have a smoking policy that at a minimum prevents staff from smoking in the presence of people receiving services.

Q. **Limited English Proficiency Policy**: Agency shall have a policy that describes how people with limited English proficiency will be assured meaningful access to services provided by the agency. The policy must comply with federal regulations.

IV. INDIVIDUAL CASE MANAGER STANDARDS

A. The case manager must be knowledgeable of and comply with all agency policies and standards.

B. A case manager shall be knowledgeable about the full range of services available to individuals in their region and shall ensure that individuals are informed of available resources and services. The case manager will make any needed referrals.

C. A case manager shall provide service in an efficient, effective and collaborative manner to avoid duplication of services, unnecessary costs, and administrative tasks.

D. A case manager shall respond to requests for information and/or assistance from individuals in a timely manner.

E. A case manager shall inform all individuals of the agency's grievance procedures.

F. To the extent possible, a case manager shall ensure the person receives person-centered services in the least restrictive and most appropriate setting in accordance with his or her needs and preferences, as required by the U.S. Supreme Court Olmstead decision. (See Appendix A.)

G. A case manager shall recognize self-neglect behaviors and offer intervention, when such behaviors jeopardize the person's wellbeing. For people not enrolled in Choices for Care, a referral shall be made to the AAA (for adults age 60 and older) or the regional Designated Agency for adult mental health (for adults under age 60).

H. A case manager shall respect the person's rights, strengths, values and preferences, encouraging the individual to create, direct and participate in their individualized written person-centered plan to the fullest extent possible.

   1. The person may involve a caregiver or a legal representative in decision making. A legal representative may be a legal guardian appointed by probate or family court with specific duties outlined in the court order, an attorney or power of attorney.

   2. People have the right to make their own decisions and decide who they want to be involved in decision making. In the event that a person has a guardian or agent, the case manager will involve him/her in accordance with that individual's legal responsibility. When a person does not appear to have the capacity to make decisions and there is no legal guardian or agent the case manager shall refer to the agency policy on self-neglect.

   3. The case manager will provide a person-centered process that is timely and occurs at times/locations of convenience to the individual.

4. Person-centered planning must reflect a process that the setting in which the individual resides is chosen by the individual.

5. A case manager shall ensure that a person has the right to receive services under conditions of acceptable risk. "Acceptable risk" is the level of risk an individual and/or his/her guardian, if there is one, is willing to accept after the informed consent process. A case manager may work with the individual and the service provider to develop a Negotiated Risk Agreement when necessary.

I. Assessment: A case manager, with input and participation by the person and his/her support network, shall assess the individual's strengths and needs using the assessment tool(s) approved by ASD.

1. A case manager shall update the assessment at least annually, or at any time there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed.

2. A case manager shall make every effort to assure the completeness and accuracy of the initial assessment and any subsequent reassessments.

3. Assessments need to be completed in compliance with Choices for Care and other program protocol.

J. Goals: When a person requires case management assistance for complex issues the case manager along with the individual and his or her support network shall identify person-centered goals.

K. Planning: Using the information from assessments and in consideration of the individual's person-centered goals, the case manager shall discuss all available options with the individual and his or her support network; and, agree upon strategies built upon the strengths of the individual to achieve these goals. Strategies shall describe the specific service or support to be provided, the person responsible for carrying out the strategies and the target date as agreed upon by the person. The initial goal and strategy identification shall be completed within 60 days of completion of the assessment.

L. Monitoring and reviewing: A case manager shall monitor the delivery of formal and informal services and supports to ensure that services are being provided as planned, to ensure that the person's identified needs are being met, and goals are being pursued. Monitoring shall include regular contact with the individual, caregivers, and service providers. The individuals' goals and strategies shall be updated to reflect the annual reassessment or more frequently if there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed. For more specific guidelines, refer to program and agency requirements.

M. Documentation: A case manager shall maintain current, complete and accurate paper or electronic files for each person including but not limited to:

1. A written release of information or documentation of why a written release of information could not be obtained.

2. The appropriate assessment form designated by DAIL.

3. Person-centered plan which is driven by the individual. The plan must:
   a. Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports the individual's strengths and preferences.
   b. Reflect the setting in which the individual resides is chosen by the individual.
   c. Reflect clinical and support needs as identified through an assessment of functional needs.
   d. Reflect individually identified goals and desired outcomes.
   e. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of paid services.
   f. Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
   g. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
   h. Identify the individual and/or entity responsible for monitoring the plan.
   i. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
   j. Be distributed to the individual and other people involved in the plan.
   k. Include those services, the purchase or control of which the individual elects to self-direct.
   l. Prevent the provision of unnecessary or inappropriate services and supports.

4. Modifications, or exceptions, to the CMS required HCBS person-centered planning process must be documented and include the following: (see definition of Modifications)
   a. Identify a specific and individualized assessed need for modification

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan
c. Document less intrusive methods of meeting the need that have been tried but did not work
d. Include a clear description of the condition that is directly proportionate to the specific assessed need
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
g. Include informed consent of the individual or their legal representative
h. Include an assurance that interventions and supports will cause no harm to the individual.

5. Case notes that shall focus on the individual's progress and any emergent issues that need to be addressed.

6. Other correspondence received or sent which is relevant to individual.

7. Other documents required by specific programs and services, such as copies of applications, notice of decisions, etc.

8. Guardianship/ Power of Attorney and other advanced directives must be documented in the assessment.

9. If the case manager is taking direction from a legal representative, there must be a copy of the legal documentation maintained in the individual's case management record. (e.g. Guardianship or Power of Attorney documents.)

10. Documentation of Negotiated Risk Agreement (if applicable).

11. Documentation of required reporting of suspected abuse, neglect and exploitation.

V. CERTIFICATION PROCESS

A. A case management agency is deemed certified for one to three years by the ASD when the following components have been met:

1. An Area Agency on Aging have a current approved area plan on file with the ASD ora Home Health Agency has received designation to provide Medicare home health services in the State of Vermont by Division of Licensing and Protection (DLP) through the designation or survey process.

2. ASD has completed a certification review.

3. The agency has demonstrated compliance with all requirements found in the Case Management Standards or has shown progress that is acceptable to ASD towards resolving unmet case management standards at time of initial certification or re-certification.

B. The ASD certification process includes:

1. Verification that an Area Agency on Aging has a current approved area plan on file with ASD or verification that a Home Health Agencies has received designation to provide Medicare home health services in the State of Vermont, by Division of Licensing and Protection (DLP) through the designation or survey process.

2. Approval of the policies required in the Case Management Standards.

   a. Policies shall be submitted to ASD in a manner which allows ASD to maintain an electronic file for each agency.

   b. Policies which have been approved as part of the AAA Area Plan process or as part of the Home Health Agency designation do not have to be resubmitted at the time of the initial or recertification process. (See Appendix D for a list of those policies which are included in the Agency on Aging Area Plan or Home Health designation process.)

   c. Policies relating to case management services which have been updated or altered since the previous certification review must be submitted to ASD for approval prior to the certification review process.

3. Review of complaints received and documented at ASD during the past year.

4. Consultation with the following community partners regarding the quality of case management services provided by the agency, as needed:
   - Adult Day providers
   - Waiver Team Members
   - Public Guardians

- Field Directors

5. An on-site review at the case management agency.

   a. Each agency will be notified of the review within one (1) week of the pending on- site visit. ASD reserves the right to make unannounced agency site visits with the intention to conduct a targeted review.

   b. The on-site portion of the review will last for three (3) days but may be extended at the discretion of ASD. It will include:
      - A review of individual CFC and/or OAA case management files.
      - Home-based interviews with individuals who receive case management services through CFC or OAA programs. Interviews may also include family members, surrogates and/or caregivers.
      - Individual interviews with case management staff.
      - Interviews with the Agency Director, Long Term Care Director, and/or Case Management Supervisor(s) to discuss the quality of case management services, the implementation of policies and procedures, and program understanding within the agency.
      - An exit interview with the agency director and others the director may choose to invite. This interview will summarize the preliminary findings of the review.

   c. The review sample will be limited to 4 to 6 individuals participating in High/Highest Needs CFC and/or OAA programs. The sample selection will be announced during day one of the review and may be expanded at the discretion of ASD. Records of other recipients of services may be reviewed as required.

   d. The discovery period of the review process will last no more than fourteen (14) consecutive days. This timeframe may be extended by mutual agreement between ASD and the agency.

   e. A written report addressing the results of the Certification Review will be available to the agency within thirty (30) days from the end of the review process.
      - The written report will consist of a brief letter which states the date of the review under discussion and the Review Grid completed by the DAIL reviewer at the time of the review.
      - A brief statement of particular areas of strength of the agency.
      - A statement of whether all of the Standards were met or not. If any area was not met, the letter will refer the reader to the Review Grid.
      - Any corrective action plan required from the agency must be received by ASD within 15 days from the date the agency received the ASD written report of the results of the quality review.

6. The final review report will have one of the following recommendations.

    a. Three-year certification: No corrective actions or recommendations.

    b. Two-year certification: Granted at the discretion of ASD if the agency's corrective action will bring an unmet standard into full compliance within a month of submittal to ASD.

    c. One-year certification: Granted at the discretion of ASD if the agency's corrective action plan will bring an unmet standard into full compliance after follow-up review visit(s).

    d. Suspension of certification: Granted at the discretion of ASD pending corrective action plan acceptance and follow- up review.

7. Certified Case Management agencies will be listed on the DAIL website. A redacted copy of the certification documents will be available to the public upon request.

8. The following documents will be used as technical references during the Certification Review process:
    a. Case Management Standards & Certification Procedures for Older Americans Act Programs and Choices for Care

    b. Case Manager Training Process

    c. Choices for Care High / Highest Needs Program Manual

    d. Older Americans Act and Accompanying Regulations

VI. APPEALS

The decision to suspend certification or to decertify may be appealed to the Commissioner of the Department of Disabilities, Aging and Independent Living.

1. The agency shall file for an appeal within 10 working days of a notice of suspension or decertification.

2. The Commissioner shall hear the appeal within 45 days of notice from the agency.

3. The Commissioner shall issue her or his decision in writing within 30 days of the hearing.

4. The agency's certification shall remain in place during the appeal process.

5. These deadlines may be increased if agreed to by both DAIL and the case management agency.

APPENDIX A

State and Federal Statutory Authority

I. **State Statute**: The Department of Disabilities, Aging and Independent Living has statutory authority to manage programs and protect the interests of older Vermonters and Vermonters with disabilities within Title 3, Chapter 53, Subchapter 004, Section 3885a of Vermont State Statutes.

The Commissioner has the authority to determine the policies and to exercise the powers and perform the duties required for the effective administration of the Department within Title 3, Chapter 53, Subchapter 003, Section 3052 of Vermont State Statues.

II. **Choices for Care**: Choices for Care is managed under Vermont's Global Commitment to Health 1115 Waiver. The Centers for Medicare and Medicaid Services (CMS) sets parameters for operations and quality management in the Code of Federal Regulations (State Assurances), Vermont's Special Terms and Conditions and Comprehensive Quality Strategy.

III. **Home and Community-Based Services (HCBS) Medicaid Regulations** – New HCBS Federal regulations (2014) set forth new requirements for HCBS settings standards and person-centered planning for people receiving services in home-based settings. The regulations are intended to enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

IV. **Older Americans Act**: The Older Americans Act (OAA) requires the State to be responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all state activities under the Act. Vermont is also responsible for setting specific objectives for each area for all services under the Act. 42 U.S.C.§3025 (a)(1)(c).

Vermont uses Title III-E funds to support case management activities. Vermont is required to establish standards and mechanisms designed to assure the quality of services, and to establish quality standards and mechanisms and accountability. 42 U.S.C.§3030s-1(e)(l).

OAA regulations require Vermont to develop policies governing all aspects of programs operated under Title III and to be responsible for the enforcement for these policies. (45C.F.R.§§1321.11 and 1321.17).

V. **Olmstead Decision**: On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate;

(2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Vermont STP Final Approval Activities (19)

SECTION	CMS COMMENT	ACTION
Person Centered Planning (1)	Clarify in the CQS that Person-Centered Planning criteria do not have a phase-in allowance; these criteria were effective March 17, 2014.	Group Agreement Required: Vermont agrees to add language to the CQS that clarifies that the Person-Centered Planning criteria effective March 17, 2014 are not subject to phase-in allowance.
Site Specific Settings Assessment (5)	Provide the total number of settings subject to the HCBS Settings Rule by specialized service population group.	Group Agreement Required: • CFC Shared Living/Provider Home: 12 providers serving approximately 94 people in _____ shared living (private) homes. • TBI Shared Living/Private Homes: 11 providers serving approximately 79 people in _____ homes. • Adult Day: 14 providers serving approximately 200 people.
	Confirm that the STP accurately includes all group residential and non-residential settings in its assessment and validation activities.	Yes. Choices for Care ERC services provided by Licensed Residential Care Homes and Assisted Living Residences are excluded as PNMI.
	Confirm in the STP that providers completed a distinct self-assessment for each individual setting providing Medicaid-funded HCBS.	Need some help interpreting this. Should we discuss with CMS?
	Confirm the self-assessment process evaluates the experience of individual's receiving HCBS in each setting.	Talk about sampling plan. Should we discuss with CMS?
	Outline what the state will do to monitor compliance of individual private homes with the regulatory criteria over time.	Group Agreement Required: Should this requirement get added to ongoing monitoring section?
Validation of Site Specific Settings Assessment (3)	Provide additional details in the STP about the state's plan to validate the provider self-assessments, and how the state will assure that each setting providing Medicaid-funded HCBS will be assessed and validated, using at least one independent validation strategy.	Talk about sampling plan. Should we discuss with CMS? Group Action Needed: Provide detail re: validation strategies.

	Provide information in the STP about the state's plan for site visits, including the number of settings to receive site visits and when and how they will occur.	Like above...
	Once the state's validation activities have been completed, provide an updated chart of the number of sites falling into categories of compliance (a) fully compliant with the settings criteria, (b) could come into full compliance with modifications, (c) cannot comply with the federal settings criteria, or (d) are presumptively institutional in nature.	Group Action Needed: Develop tables for DS, TBI, CFC, CRT, and EFT using these 4 categories. Special focus should be on categories C and D.
Remediation Strategies (7)	Describe the process that the state will take to assure that any discrepancies between the consumer responses and/or other validation strategy and provider self-assessments are addressed.	Group Action Needed: Need detailed responses for DS, TBI, CRF, CRT, and EFT
	Describe in more detail what state strategies will be employed to support site-specific remediation.	Group Action Needed: Like above...
	Describe the process the state will employ to track progress with site-specific corrective action plans to ensure HCBS settings will achieve compliance by the March 2022 deadline.	Group Action Needed: Linked to above – asks about project management. My sense is that each will need a project manager and workplan – but we can discuss.
	Provide a timeline and a description of the processes for assuring that beneficiaries, through the person-centered planning process, will be given the opportunity, the information and the supports necessary to make an informed choice among options for continued service provision, including in an alternate setting that aligns, or will align by the end of the transition period, with the regulation. CMS requests that this description and timeline specifically explain how the state intends to assure beneficiaries that they will be provided sufficient communication and support including options among compliant settings, and assurance that there	Asking for a description and timeline for transition period (notified of finding, provided with information and support, transitioned, etc.). Group Agreement Required: Not sure of scope here...does that only apply to categories B, C, and D above? Should we discuss with CMS?

	will be no disruption of services during the transition period.	
	Provide an estimate of the number of individuals who may need assistance in this regard.	Group Agreement Required: Should this be part of the table of compliance categories above?
	Provide clarity on the way the state will ensure that beneficiaries have access to services in non-disability specific settings among their service options for both residential and non-residential services.	Group Agreement Required: Need help interpreting.
	Indicate the steps the state is taking to build capacity among providers to increase access to non-disability specific setting options across home and community-based services.	Group Agreement Required: Need help interpreting.
Ongoing Monitoring of the Settings (1)	Provide information on the estimated timeframes for implementing each element of the oversight and monitoring plan.	Group Action Needed: Identify key elements of ongoing monitoring and oversight of the settings, who is responsible, and when they will be completed.
Heightened Scrutiny (1)	Provide further details about the criteria or deciding factors that will be used consistently across reviewers to make a final determination regarding whether or not to move a setting forward to CMS for heightened scrutiny review.	Group Agreement Required: Clarify heightened scrutiny review process. Determine criteria or deciding factors – and agree that common review tool is possible.
Milestone Template (1)	Send the updated milestone document to CMS. This chart should reflect anticipated milestones for completing systemic remediation, settings assessment and remediation, heightened scrutiny, communications with beneficiaries and ongoing monitoring of compliance.	Group Action Needed Update milestone document. We have done this already – but it has not been forwarded to CMS. I will edit – based on our discussion of these items – send back out to you for review – and then forward to CMS.

Kennedy, Alice

From: Tierney-Ward, Megan
Sent: Thursday, November 16, 2017 10:49 AM
To: Bedard, Colleen
Cc: McMann, Angela; Dalley, Jessica
Subject: website document
Attachments: CFC HCBS Final Alignment Report w fixed links 11.16.17.pdf

Hello,
Please replace the attached document on the website. The only difference are the hyperlinks which have been fixed to accommodate our new website.

Instructions:

1. Save the attached new PDF document in the ASD website folder and rename it **"Choices for Care Alignment report FINAL"**
2. Sign onto the ASD website, find the old document **"CFC HCBS Final Alignment Report 12.18.15"** and replace it with the new document.
3. Go to the link called "**Choices for Care Alignment Report FINAL**" on this website page and relink the new document: http://asd.vermont.gov/special-projects/federal-hcbs

Did you resolve whether the documents are to be saved in the ALLDAIL folder or on the ASD folder?

Thanks,

Megan

HCBS QCS July 2018 00941

VERMONT OFFICIAL STATE WEBSITE

FEDERAL HCBS REGULATIONS ASSESSMENT AND IMPLEMENTATION PROJECT

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS) (https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving Medicaid funded services have full access to the benefits of community living and are able to receive services in the most integrated setting. As part of Vermont's Global Commitment to Health (GC) (http://dvha.vermont.gov/global-commitment-to-health/vermont-global-commitment-to-health-approval-documents?portal_status_message=Changes%20saved.) waiver, effective January 30, 2015, CMS has asked Vermont to provide assurances in its Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy) that the State's Managed Long-Term Services and Supports (MLTSS) are in compliance with certain aspects of the HCBS rule, specifically those related to the setting requirement and person- centered approaches for service planning.

- CMS HCBS Regulations (https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider)
- Vermont GC Comprehensive Quality Strategy (http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy)
- CMS 3-Year Extension Announcement (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-09.html)
- CMS Letter to States (https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf)
- CMS Guidance Website (https://www.medicaid.gov/medicaid/hcbs/guidance/index.html)

Program Documents & Tools

HCBS-QS-July2018-00942

- DAIL Provider Self-Assessment Survey (/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf)
- Choices for Care Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_Choices_for_Care.pdf)
- Choices for Care HCBS Reference Table - Home-Based (/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf)
- Choices for Care Reference Table - Enhanced Residential Care (/sites/asd/files/documents/Regulations_Table_for_ERC.pdf)
- Choices for Care Work Plan (updated December 2016) (/sites/asd/files/documents/Choices_for_Care_HCBS_Work_Plan_Revised_December_2016.pdf)
    - DRAFT Case Management Standards Revision (/sites/asd/files/documents/DRAFT_Case_Management_Standards.pdf)
    - DRAFT List of Case Management Standards Changes (/sites/asd/files/documents/Case%20Management%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Adult Day Standards Revision (/sites/asd/files/documents/DRAFT_Adult_Day_Standards.pdf)
    - DRAFT List of Adult Day Standards Changes (/sites/asd/files/documents/Adult%20Day%20Standards%20List%20of%20Changes.pdf)
    - DRAFT Universal Provider Standards Manual Section (/sites/asd/files/documents/DRAFT%20Universal%20Provider%20Standards%20Manual%20Section.pdf)
    - DRAFT Adult Family Care Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Adult_Family_Care_DRAFT.pdf)
    - DRAFT Rights & Responsibilities Manual Section (/sites/asd/files/documents/CFC_Manual_Section_Rights%26Responsibilities_DRAFT.pdf)
    - DRAFT Live-In Care Agreement Form 808 (/sites/asd/files/documents/CFC_LiveIn_Requirements%20808%20Form%20DRAFT.pdf)
    - FINAL Case Management Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf)
    - FINAL Adult Day Standards Revision (http://asd.vermont.gov/sites/asd/files/documents/Adult_Day_Standards_January_2017.pdf)
- TBI Program Alignment Report FINAL (/sites/asd/files/documents/HCBS_Alignment_Report_TBI.pdf)

HCBS QRS July 2018 000943

- TBI Program Reference Table (/sites/asd/files/documents/TBI_Reference_Table_HCBS_Regs.pdf)
- TBI Program Work Plan (/sites/asd/files/documents/TBI_HCBS_Work_Plan.pdf)

TAGS:
Human Rights (/tags/human-rights) |
Long Term Services and Supports (/tags/long-term-services-and-supports) |
Medicaid (/tags/medicaid) | Standards (/tags/standards)

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Limited English Proficiency (LEP)

This is a Division of the
Department of Disabilities, Aging and Independent Living
under the Agency of Human Services

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NCI

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HCBS QCS July 2018 000944

Vermont State Partners

BIAVT

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VCIL

VHCA

VNA's of VT

Vermont 211

More Vermont Partners

Performance Dashboards

Agency of Human Services Results Scorecard

DAIL Department Scorecard

State of Vermont

Comprehensive Quality Strategy Systemic Assessment

Section III State Standards:

Home and Community Based Services

Choices for Care Managed Long-Term Services and Supports

December 2015; Updated November 21, 2016

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Background

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS's intent to ensure that individuals receiving services and supports under 1915(c) HCBS waivers, 1915(k) (Community First Choice), and 1915(i) State Plan HCBS Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting.

The State of Vermont has been particularly progressive in pursuing a home- and community-based continuum of care that offers meaningful community integration, choice, and self-direction, and strives to promote health, wellness, and improved quality of life. In doing so over the years, the State has used many authorities available under the Medicaid State Plan's rehabilitation option, as well as former 1915(c) waivers and Medicaid Section 1115 Demonstration projects. Additionally, guidance and assurances for home- and community-based care in Vermont are codified in statute or placed in rule. As a result, the term "home and community based" is used in Vermont to represent a broad array of services and supports that may not be typical of 1915(c) populations and CMS rules in other states, but that have been authorized under its Section 1115 Demonstration.

As part of Vermont's Global Commitment to Health (GC) Section 1115 Demonstration amendment, effective January 30, 2015, CMS has asked Vermont to provide assurances that the State's Managed Long-Term Services and Supports (MLTSS) in the Choices for Care Program are in compliance with certain aspects of the HCBS rule, specifically those related to the setting requirement and person-centered approaches for service planning. Two specific Special Terms and Conditions (STC's) from the GC Section 1115 Demonstration are summarized below:

- Person-centered planning (i.e., the process, the service plan, and the review of the service plan) will be in compliance with the characteristics set out in 42 CFR 441.301 (c)(1)-(3) (STC #29)

- Compliance with the characteristics of home- and community-based settings in accordance with 42 CFR 441.301 (c)(4) for Choices for Care Services (*i.e., those not found in the Vermont State Plan*) (STC #32).

Because of Vermont's public managed care delivery system, the State is integrating person-centered planning and integrated community setting assurances into its Comprehensive Quality Strategy for all Specialized Programs. Regardless of the setting type that beneficiaries choose, Vermont's values are in alignment with the Federal HCBS values. As such, at its discretion and over time, the State's Comprehensive Quality strategy will review the rules and guidance supporting all Special Health Need Populations served under the Demonstration and services provided in community settings authorized under the State Plan and the Global Commitment Demonstration. This report focuses on the Choices for Care Program.

HCBS Institutional Level of Care for Eligibility and Enrollment

Persons may become eligible for participation in the Choices for Care (CFC) Long-Term Care program by meeting Medicaid Long-Term Care eligibility rules, 1915(c) institutional eligibility rules, GC Demonstration population rules, and by also meeting clinical criteria for High, Highest, or Moderate Needs services. Persons designated as High or Highest Needs must meet nursing facility level of care, and persons with Moderate Needs are at risk for nursing home level of care. Persons with Moderate Needs are eligible for a limited benefit package to assist them in remaining in their home. Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules and are in the High or Highest Needs Group (i.e., meeting a nursing facility level of care).

Program Settings and Services

In the CFC program consumers have equal access to an array of traditional State Plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing, home–based, and other rehabilitative service options. The final service package is based on consumer choice, individualized planning, medical necessity (including level-of-care determinations), and medical appropriateness; thus, individual plans may include institutional, home-based, and other rehabilitative-based services as part of their person-centered planning process.

The majority of Choices for Care services are provided to participants in their homes. However, persons may also choose to reside in one of the following out-of-home setting types:

Adult Family Care (AFC) – A 24-hour, home-based, shared living arrangement providing care for no more than two persons unrelated to the provider. Adult Family Care homes must meet DAIL safety and accessibility standards prior to participant placement, with inspections every three years. Each AFC home maintains a contract with a Host Agency responsible for quality oversight and case management services on behalf of the participant. An Adult Family Care Coordinator from the host agency assists the home provider and participants in creating a person-centered care plan and live-in agreement. Home providers do not serve as case managers or guardians for persons in their care.

Enhanced Residential Care (ERC) – Residential Care Homes in Vermont are licensed to provide room, board, and personal care to three or more residents unrelated to the provider. CFC ERC services involve a daily package of services provided to individuals residing in an approved, Vermont Licensed Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). All CFC ERC providers must also be enrolled as Medicaid Assistive Community Care Service (ACCS) providers and receive a Medicaid payment for Assistive Community Care Services (i.e., private non-medical institution), as well as an enhanced residential care payment for services to CFC participants. Prior to participation in the CFC ERC program, providers must request a variance of licensing standards that restrict residential admissions to persons who do not meet Nursing Facility level of care. A summary of the State Plan and Choices for Care authorities and payment types are provided on Table 1 on the following page.

Nursing Facility (NF) – 24-hour nursing care and supervision provided by a VT Licensed Nursing Facility.

Table 1 State Plan and Choices for Care Authorities Related to ERC Providers

Beneficiary Type	Provider ACCS Enrollment	Payment Type	State Regulations
General Public	Not required	Self	RCH and ALR Licensing Regulations
Medicaid Recipient	Optional	Self or ACCS	RCH and ALR Licensing Regulations including ACCS enrollment
Choices for Care Recipient	Required	ACCS plus CFC Enhanced Residential Care	All of the above plus Choices for Care Regulations and Universal and Other Provider Requirements

In addition to these residential arrangements, CFC participants who are residing in their own homes or in an Adult Family Care setting may also receive Day Health Rehabilitation from a State-Certified Adult Day Service provider. Day Health Rehabilitation is a State Plan service and is defined below.

> Day Health Rehabilitation: Services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services.

Table 2 below shows the service array available to Choices for Care participants and their coverage authority.

Table 2: Choices for Care Program Benefits

42 CFR 440.180 HCBS Service	Choices for Care Benefit	Coverage Authorization (Medicaid State Plan or Global Commitment)
Case Management	Case Management	GC
Home Maker	Home Maker - Moderate Needs Group only	GC
Personal Care	Personal Care	GC
Adult Day Rehabilitation	Adult Day	State Plan -Day Health Rehabilitation
Habilitation	Enhanced Residential Care - Assisted Living Residences	State Plan - Private Non-Medical Institution (Assistive Community Care Services)
	Enhanced Residential Care – Level III Residential Care Home	State Plan - Private Non-Medical Institution (Assistive Community Care Services)
	Adult Family Care	GC
	Nursing Facility Care	State Plan- Nursing Facility
Respite	Respite Care (in home or foster home)	GC
Other Cost-Effective Alternatives	Companion Care	GC
	Assistive Devices and Home Modifications	GC
	Personal Emergency Response System	GC

Due to the nature of Vermont's Medicaid State Plan, the GC STCs, and Medicaid Managed Care rules, expenditures for the full continuum of service (home based, shared living, enhanced residential, and nursing facility care), commensurate with participant needs and choice, are allowable under Vermont's Section 1115 Demonstration.

Policy Overview

The Choices for Care program has a variety of written materials associated with its operations. These materials range from APA-promulgated rule and licensing standards to operations manuals, provider certification standards, audit tools, and training guides. One document, the DAIL Case Management Action Plan Guide is currently not in use, it was reviewed to assess its applicability and need for revision. The following documents were reviewed as part of this project:

- Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations (February 2009)
- Choices for Care Long-Term Care Medicaid Program Manual (August 2013 Revised)
- Choices for Care Participant Handbook
- DAIL Revised Case Management Standards Certification Procedures (June 2009 – no longer on website, Case Management Standards Revised January 2017)
- DAIL Case Management Action Plan Guide (Inactive and under consideration for revision-available upon request from DAIL, Adult Services Division, 280 State Drive, HC2 South Waterbury VT 05671-2070)
- Residential Care Home Licensing Regulations (October 3, 2000)
- Assisted Living Licensing Regulations (March 15, 2004)
- Adult Family Care Training Materials (September 1, 2013 – no longer available online)
- Adult Family Care Sample Live-In Agreement Template
- Standards for Adult Day Services in Vermont (Effective March 1, 2012 – no longer available online, Standards for Adult Day Services updated January 2017)

Appendix A and B provide a more detailed crosswalk of Vermont policy documents to the federal HCBS rules. Elements responsive to federal rules were scored using the following categories:

Alignment:	State policy documents show alignment with federal rules.
Partial:	State policy documents show general alignment with federal rules, but lack specificity.
Silent:	State policy documents do not mention specific terms contemplated in federal rule.
Non-Comply:	State policy documents are in conflict with the terms contemplated in federal rule.

Brief summaries of Adult Family Care and Enhanced Residential Care policies are provided below.

Adult Family Care: Choices for Care materials for Adult Family Care state that the goal is to provide individualized supports in an environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity. The home provider is expected to ensure that the environment promotes a positive domestic experience and to assist the person in realizing their maximum potential for independence.

The Adult Family Care Participants' rights agreements include stipulations that the live-in agreement must address such concerns as, but not limited to: visitation, diet/food, and access to activities in the community. All parts of the agreement must be based on the person's desires and the person-centered plan, and be approved by the participant or his or her legal representative in a written live-in agreement.

DAIL provides a sample agreement; the household arrangement section focuses on whether each identified physical space (bedroom, bathroom, kitchen, living room, and other space) is shared or private. The template includes negotiated risk, conditions regarding any termination of the agreement, room and board, and acknowledgments of Participants' Rights. Other considerations are noted in a free-form text box at the end, identified as "Other." Private or semi-private accommodations are agreed to by each specific arrangement and noted in the live-in agreement. No more than two persons needing care may reside in a single Adult Family Care setting. AFC home providers do not serve as case managers or control participants' finances or health decisions.

Enhanced Residential Care: CFC ERC services may be provided in an Assisted Living Residence or a Residential Care Home-Level III. These Choices for Care settings are governed by three sets of regulations (see Table 1 above), and all serve the general public as well as Medicaid and Choices for Care enrolled participants. Residential Care Home and Assisted Living Licensing Regulations address choices, physical accessibility, individual rights to privacy, and control. Licensing regulations also indicate that a home must respect the individuality of its residents and promote maximum independence. Written agreements are required for room and board, negotiated risk contracts, and the agreed-upon service options. The CFC Universal Provider Qualifications and Standards listed in the CFC Long-Term Care Medicaid Manual require, among other things, that all CFC providers encourage and assist participants to direct as much of their care as possible and that they maintain safeguards and procedures to address potential conflicts of interest.

Assisted Living Residences provide specificity related to lockable doors, private units, and lease agreements. Residential Care Homes, Level III Regulations provide overarching values related to privacy, dignity, and independence. These regulations allow for providers to structure and define visiting hours, meal plans, and daily social/recreational routines within the parameters outlined in regulation. Residential Care Home regulations do not specify whether a resident's room must be lockable.

In addition to examples of autonomy and privacy found in the federal rule, Vermont Residential Licensing Rules provide that residents also have a right to:

- communicate privately;
- receive and send unopened mail;
- have access to a phone;
- refuse care (to the extent allowed by law);
- refuse visitors; and
- leave the residence at any time and be away for more than 24 hours.

Persons in ERC settings are receiving an all-inclusive package of services and do not receive case management services from an outside agency. Persons who choose to receive services in an ERC setting are also by default agreeing to potential limitations in: visiting hours, transportation, independent access to food or meal preparation, and the timing and type of social recreational options. Participant choice of facility may also include Residential Care settings that are located on community hospital or private nursing facility grounds.

Summary and Options for Next Steps

Choices for Care statutory and regulatory framework appears to substantially align with the values in the federal framework and requires many of the same safeguards. All residential arrangements in the Choices for Care program, including Adult Family Care, must be commensurate with assessment findings, individualized long-term service and support goals, consumer abilities and desires, and meaningful choice per Choices for Care regulations. However, specific DAIL guidelines, checklists, model agreements, and quality oversight tools to ensure that providers are using best practices could provide more detailed guidance. For example, Choices for Care regulations and DAIL Case Management Standards require person-centered planning; however, guidelines and training tools do not describe what that planning entails or offer specific steps or checklists that provide examples of person-centered planning practices or practices that are not acceptable.

DAIL licensing and certification activities include a review to determine whether various standards are being met, but may not include quality or provider's performance data related to how well the standards are implemented. Along these lines, the Adult Family Care standards indicate that live-in agreements and care plans should address all aspects of the participant/provider agreement with respect to visitors, privacy, community access, and diet and nutrition; however, DAIL's sample template largely deals with physical space, risk, lease, and room and board payments. Similarly, the Adult Family Care Service Authorization form provides the service type, duration, and rates, but does not provide a summary overview of care plan goals, objectives, or agreed-upon modifications.

A preliminary list of options for enhancing quality oversight and providing more specific and direct guidance related to State and federal values and rules is provided in Table 3 on the following page. This list should not be considered exhaustive; more extensive stakeholder engagement may yield additional opportunities for ongoing quality assessment and improvement.

Table 3 Preliminary List of Options for Quality Assessment and Improvement

Preliminary List of Options for Quality Assessment and Improvement	
Potential Next Steps	**Considerations**
Revise Residential Licensing Regulations to include more detailed standards related to specific setting characteristics	• Regulations define State expectations for all settings regardless of type • Licensing reapplications are required annually • Revisions may also impact providers not involved with the Choices for Care or Medicaid program • Regulation changes do not guarantee quality monitoring and improvement processes • Regulatory revision process may be time consuming and delay implementation of desired provider change
Require providers receiving ERC payments under CFC to meet additional detailed standards, such as the submission of quality strategies and data with each ERC variance request and/or a HCBS self-assessment	• Standards could clearly define DAIL expectations for all settings regardless of type • Standards could engage ERC providers in quality oversight and improvement planning • Small providers may not have quality planning resources and may no longer participate in the ERC program
Conduct periodic consumer and stakeholder assessments of provider adherence to standards	• Consumer self-report could allow for more direct and targeted quality improvement • Stakeholders could include family members, legal guardian, and ombudsmen reports
Enhance DAIL Case Management Certification Standards and audits with a review of specific details regarding person-centered planning and HCBS settings characteristics	• Standards could focus provider attention on the importance of case management in monitoring care planning and community settings • Existing audit tools could be enhanced to include key information related to the quality-of-care planning processes and the case manager's oversight of alternative settings • Audits may require more resources if content is expanded
Enhance CFC annual service authorizations (e.g., hours and rates) with additional DAIL review of information regarding care planning process (e.g., level and type of participants, areas addressed, and goals)	• Current AHS plans to update its IT structure provide an opportunity for DAIL to define information needed to augment current provider performance and quality monitoring
Update or create tools and guidance that support desired characteristics such as: • Person-centered planning checklist for case management and ERC providers • Sample AFC live-in agreements • Sample Residential agreements	• Updating sample templates could more clearly define State expectations for all settings regardless of type • Checklist would provide opportunity for performance monitoring and more direct quality improvement planning

Preliminary List of Options for Quality Assessment and Improvement	
Potential Next Steps	**Considerations**
• Participant handbooks • Case Management Plan Action	• Revising current trainings materials would provide ongoing access to clear examples of State expectations
Ensure that the person-centered planning elements delineated in the DAIL Case Management Standards are applicable to all agencies (ERC and Adult Family Care Host Agencies) that support assessment and care planning services.	• Creating a subset of universal case management standards for all settings could more clearly define State expectations regardless of type

Appendix A: HCBS Settings Requirements and Vermont Regulation and Policy Crosswalk

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
<u>*1. Commensurate with a persons individualized plan, needs and abilities*</u> - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS	**CFC Regulations** Sec. 1 A; Sec. II. A; Sec. VII. B 5, B 6, C. **Case Management Standards & Certification Procedures** Section IV. A. **CFC Program Manual** Sec. IV. 11 D. 8, E. **Adult Family Care Training Materials** Goal and General Policies; Sec. 1. b-c; 2 b. **Adult Family Care Participant Rights Standards for Adult Day Services** Sec. I. A, B Sec. XIV. F	• CFC regulations assume community living in the purpose statement to equalize the entitlement between home and community services and nursing facility but do not specifically discuss each type of setting. Regulations provide that persons receive services in settings of their choice, commensurate with their abilities and person-centered plans. • Case management standards support planning that promotes the least restrictive, most appropriate setting in accordance with needs and preferences. • ERC settings accept Medicaid and non-Medicaid admissions and are not disability specific. • ERC settings must also be enrolled ACCS providers and as such receive State Plan payments as Private Non-Medical Institutions (PNMI). While Vermont programs are often small and based in community neighborhood settings, PNMI facilities may also be associated with or on the grounds of, community hospitals and private nursing facilities. • Employment and access to competitive work is not a goal area within Choices for Care. • Participants' Rights include individuality and community participation. • Adult Day Center Standards require that facilities be located to provide the greatest accessibility to the communities from which participants are drawn, in proximity to other services, and convenient to private and public transportation. • Adult Day services are designed to assist adults to remain as active in their communities as possible and ensure optimal functioning.	Alignment	Partial Due to nature of PNMI and Licensing Standards some settings may be located on the grounds of private hospitals or nursing facilities.	Alignment
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.	**CFC Regulations** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); A 2 (c) and (g); C. **CFC Program Manual** Sec. III. C 7. Section IV. 11, D 8.	• CFC regulations provide that persons receive information on all options available within the Choices for Care Program. • Case management certifications and service planning standards provide that the person receive services in the least restrictive and most appropriate setting in accordance with needs and preferences.	Alignment	Alignment	Alignment

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	**Case Management Standards & Certification Procedures** Section IV. C. **Adult Family Care Service Plan** (Consent Statement regarding options)	• Staff is required to discuss all available long-term care options as part of the application process, including choice of settings; however, it is unclear where the setting choice is documented for ERC. • Assistive Community Care Services (e.g., Enhanced Residential Care Level III and Assisted Living Residences) are facilities open to the general public looking for enhanced support as they age. They are non-disability specific options available to Choices for Care Program participants. Private units are available depending on the specific facility and its unique arrangements. • All settings require separate room and board agreements.			
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	**CFC Regulations** Sec. XIII. B 1-7 **Adult Family Care Participants' Rights Agreement** **Residential Care Homes Licensing Regulations** Sec. 5.14 Sec. 6 **Assisted Living Licensing Regulations** Sec. I. 1.1, Sec. VI. 6.7 **Standards for Adult Day Services** Sec. I. A Sec. VIII. C Sec X. A, B, G, J, K,	• CFC Regulations require processes to prevent and address abuse, neglect, and exploitation including, but not limited to, long-term care ombudsmen services. • Certification standards and service planning guidelines include participants' rights agreements that call for the safeguarding of rights of privacy, dignity, and freedom of coercion, restraint , and reprisal.	Alignment	Alignment	Alignment
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making	**CFC Regulations** Sec. VII. B 5 **CFC Program Manual** Sec. III. C 7.	• Adult Family Care providers are expected to ensure that the environment promotes a positive domestic experience and to assist the person in realizing maximum potential for independence.	Alignment	Alignment	Alignment

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
life choices, including but not limited to, daily activities, physical environment, and with whom to interact	Sec. IV. 11 D 8, E **Case Management Standards & Certification Procedures** Sec. II. Sec. IV. B 1-3 **Residential Care Home Licensing Regulations** Sec. 1.1; 5.5(b); 5.10 (e) (2) Sec. VI. **Assisted Living Licensing Regulations** Sec I. 1.1 Sec VI. 6.7; 6.9(a); 8.1 **Adult Family Care Training Materials** Goal and General Policies At a Glance 1.b-c; 2.b **Adult Family Care Participant Rights Standards for Adult Day Services** Sec. I. A, B Sec. X. A, B, F Sec. XII. D	• Adult Family Care is expected to include community access, leisure time activity, and participation in community functions. • Adult Family Care and Residential Care Home Participants' Rights include life choices such as the right to visitors and the right to refuse visitors, as well the right to a phone and mail, and the right to leave the residence and be gone for more than 24 hours at any given time. • The Adult Family Care participants' rights agreements include stipulations that the live-in agreement must address such concerns as, but not limited to: visitation, diet/food, access to activities in the community, and visitors. • Case managers are required to assist persons to remain as independent as possible in accordance with their wishes. • Case management standards include respecting participants' rights, strengths, and values; encouraging the person to create, direct, and participate in the plan and make their own decision about who to involve; creating acceptable risk agreements; and developing negotiated risk agreements when necessary. • Residential Care Home licensing regulations require settings to promote personal independence in a home-like environment; respect dignity, accomplishments, and abilities; and encourage participation in own ADL's, care planning, and self-administration of medication for persons who are capable. • Assisted Living Licensing Regulations provide for the promotion of individuality, privacy, dignity, self-direction, and active participation in decision making; care plans are required to support dignity, privacy, choice, individuality, and independence. • Assisted Living Licensing regulations require a daily program of activity, including periodic access to community resources. • Participants have the right to refuse any services or activities offered.			

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
		• Adult Day Services are designed to assist adults to remain as active in their communities as possible and ensure optimal functioning. Standards include optimizing self-direction, autonomy, and choice.			
5. Facilitates individual choice regarding services and supports, *and who provides them*	**Choices for Care Regulation** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C **Case Management Standards & Certification Procedures** Sec. IV. A, B, C **CFC Program Manual** Sec. III. C 7 Sec. IV. 11, D 8, E **Adult Family Care Training Materials** Goal and General Policies; Sec. 1. b-c, 2. b **Adult Family Care Participant Rights** **Adult Family Care Service Plan** (Consent Statement) **Standards for Adult Day Services** Sec. I. A, B Sec. X. A, B Sec. XI. D4	• All Participants choose where to receive their long-term services and supports. • Participants choosing Adult Family Care receive case management from a host agency. The host agency is responsible for contracting with the home provider and facilitating an acceptable match of shared living setting and a person-centered plan between the home provider and the recipient. The host agency is responsible for oversight of the care plan and following up on any client concerns with the home, plan, or other services. • Participants who choose ERC in a Residential Care Home or Assisted Living Residence receive an all-inclusive package of services that includes case management. • Participants residing in ERC settings may arrange and pay for additional services and supports. • Participants may self-manage their own care through the Flexible Choices program.	Alignment	Alignment	Alignment

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to*	**CFC Program Manual** Sec. IV. 11 D.11 **Residential Care Home Licensing Regulations** Sec. 4.3 (b), (d), (e) Sec. 5.2 (a-d), 5.3 (a), (e-h) Sec. 6.14 **Assisted Living Licensing Regulations** Sec. 3.3, 3.4 Sec. 6.5, 6.12, 6.14 Sec. 7.1 Sec. 8.2 Sec. 9 **Adult Family Care Participant Rights** Sec. 2, 13, 14	• Adult Family Care settings require a live-in agreement that includes room and board arrangements and termination agreements. • Residential Care agreements must include specific provisions with regards to occupancy, voluntary and involuntary termination of placement (30-day), and notice of any changes in rates, physical plant, policies, or other services (90-day). • Assisted Living Licensing Regulations contemplate a participant's aging in place and outline the circumstances whereby someone may be asked to leave. Requirements include a written agreement and 30-day notice period and notice of any changes in rates, physical plant, policies, or other services (90-day). • Written plans of care, reviewed at least annually, are also required to address participant services, supports, and goals.	Alignment	Alignment	N/A (not a residential service)

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
those provided under the jurisdiction's landlord tenant law.					
7. Each individual has privacy in their sleeping or living unit	**Adult Family Care Live-in Agreement** **Residential Care Home Licensing Regulations** Sec. X. 9.2(e-g) **Assisted Living Licensing Regulations** Sec. II. 3.2 Sec. XI. 11.1	• Adult Family Care placements are individually matched and allow for private or semi-private (no more than two) accommodations of the person's choosing. • Residential Care Level III licensing standards allow for private or semi-private rooms. Residents must not be required to pass through other bedrooms to reach their room, and assigned bedrooms are only to be used as personal sleeping and living quarters of assigned resident (s). • Assisted Living Residence licensing standards require residences to be homelike with private bedroom, private bath, and living space, kitchen capacity, and lockable door.	Alignment	Alignment	N/A (not a residential service)
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	**CFC Program Manual** Sec. IV. 11 E. **Residential Care Home Licensing Regulations** Sec. IX **Assisted Living Licensing Regulations** Sec. 11.2 (b), (f)	• Person-centered planning and participants' rights agreements stress privacy and planning for personal preferences; however, there is no specific reference to lockable doors. • Adult Family Care materials do not specify lockable door standards but do require that written agreements and care plans outline all shared living arrangements. • Residential Care Level III licensing standards do not specify lockable units. • Assisted Living Residence licensing standards require lockable units.	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences and needs	Partial Residential Care Home Licensing Regulations are silent regarding lockable door requirements	N/A (not a residential service)
9. Individuals sharing units have a choice of roommates in that setting	**CFC Program Manual** Sec. IV. 11 E. **Residential Care Home Licensing Regulations** Sec. IX **Assisted Living Licensing Regulations** Sec. 11.1	• Adult Family Care Guidelines only authorize 1- or 2-person homes based on person's choice. • Residential Care Level III licensing standards do not specify how semi-private placements are made. • Assisted Living residences are private occupancy unless the resident chooses to share the unit; any common areas must be available to residents at all times.	Alignment	Partial Residential Care Home Licensing regulations are silent regarding how roommates are assigned in semi-private situations	N/A (not a residential service)

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	**CFC Program Manual** Sec. IV. 11 E. **Residential Care Home Licensing Regulations** Sec. IX **Assisted Living Licensing Regulations** Sec. XI	• Adult Family Care Guidelines do not specify décor standards but do require written agreements and care plans to outline all shared living arrangements. • Residential Care Level III licensing standards do not specify standards for room décor. • Assisted Living Residence licensing standards are considered private lease units but do not specify standards for room décor.	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences	Silent	N/A (not a residential service)
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	**Residential Care Home Licensing Regulations** Sec. 7.1 (c)(4) **Assisted Living Licensing Regulations** Sec. X. 10.1 Sec. XI. 11.2 (b), 11.5 (a) **CFC Program Manual** Sec. IV. 11 E. 5 Standards for Adult Day Sec. I. A, B Sec. X. A, B, F5, Sec. XIII	• Adult Family Care Settings are required to provide for diet and nutrition based on the desires and preferences of the participant and must be documented in the written live-in agreement. • Residential Care Level III licensing standards provide for alternative meals on request but do not specify 24/7 access to food. • Assisted Living Residence licensing standards provide that the participant has his or her own unit and makes decisions about meals or purchases meal plans from the host facility. • Residential Care Home and Assisted Living Regulations provide that facilities that do offer common kitchens must make them available for participant use at all times. • Adult Day Services are structured daytime programs; however, the person has the right to refuse participation in daily activities and request alternative snacks and meals.	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences	Partial Residential Care Homes offer meal plans and are required make options available as requested by participants. Regulations are silent on 24/7 access	Alignment
12. Individuals are able to have visitors of their choosing <u>*at any time*</u>	**CFC Program Manual** IV. 11 E. 10 **Residential Care Home Licensing Regulations** Sec. 6.5 **Adult Family Care Participant Rights** Sec 5	• Adult Family Care requirements provide that homes allow visitors as determined by the participant or legal representative, including the right to refuse visitors. Visiting times must be agreed on and specified in live-in agreement • Residential Care Homes must provide for private communications and allow visitors at least from 8 am to 8 pm or longer, and residents may make other arrangements with the home for visitors; residents can refuse any visitor. • Assisted Living Residences are considered private units.	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences	Partial Residential Care Home Licensing regulations outline minimum standards (e.g., 8 am to 8 pm) not maximum	Silent

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
		• Standards for Adult Day Service are silent on visitors			
13. The setting is physically accessible to the individual	**CFC Program Manual** Sec. IV. 11. B 2, D 9 **Residential Care Home Licensing Regulations** Sec. 9.5 **Assisted Living Licensing Regulations** Sec. XI. 11.5 D	• Safety and Accessibility Inspections are required of all settings.	Alignment	Alignment	Alignment
14. Modification to HCBS Settings Requirements					
• To be eligible for the Choices for Care program, participants in the High and Highest Needs Group meet the standard for nursing facility level of care, and the use of a least restrictive home or community residential setting is based on needs, preferences, and choice. Persons requesting ERC services must receive a variance to be placed in those settings. Persons in the Moderate Needs Group are not eligible for an out-of-home residential benefit. • Changes in setting from In-home to Adult Family Care or Enhanced Residential Care and Nursing Facility Care are based on choice, needs, and medical necessity. • DAIL variance processes do not currently include request s to restrict or modify participant's choice, autonomy, or other rights; however, regulatory language as written permits DAIL to require more detailed documentation should there be a request for such a modification. • DAIL guidance related to case management documentation, reasons for a change in setting, and/or other service planning changes does not consistently include specificity noted on the following pages.					
(a) Identify a specific and individualized assessed need for modification	**CFC Regulations** Sec. XI **Standards for Adult Day Services** Sec. I. A, B Sec. X. B 8, G Sec. X.I D4	• ERC settings require variances and prior approval by DAIL for all CFC participants to ensure that the ERC facility can meet the needs of persons who meet nursing facility level of care. • Variances to any part of the CFC Regulation or policies can be requested from DAIL. Variances may only be based on the unique needs of the participants or be necessary modifications to address health, safety, and/or welfare concerns. Variances must include a description of the need, explanation of why the need cannot be met, and a description of the actual or immediate risk to health, safety, or welfare of the participant. Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
		• Changes in setting, diet, or activity plans that do not require DAIL to approve a variance from regulation or policy are made with the input of the physician, participant and legal guardian, and/or team members of the participants choosing. • Standards for Adult Day services require participant assessment and written service plans.			
(b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan	**CFC Regulations** Sec. XI **Residential Care Home Licensing Regulations** Sec. III Sec. V. 5.3 **Assisted Living Residences Licensing Regulations** Sec. 4, 6.5	• Documentation is required, however guidance is broad	Silent	Silent	Silent
(c) Document less intrusive methods of meeting the need that have been tried but did not work	**CFC Regulations** Sec. XI **Residential Care Home Licensing Regulations** Sec. III Sec. V. 5.3 **Assisted Living Residences Licensing Regulations** Sec. 4, 6.5	• To be eligible for the Choices for Care program, participants in the High and Highest Needs Group meet a standard of nursing facility level of care. Service and Participant Choice drive all decision making related to place and type of services. • ERC settings require variances and prior approval by DAIL for all CFC participants to ensure that the ERC facility can meet the needs of persons who meet nursing facility level of care. • CFC participants in the High and Highest Needs groups all meet nursing facility level of care, but may choose to receive care in less restrictive settings; changes to a more restrictive nursing facility care would be by choice or as medically directed.	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
		• CFC participants choose where to receive services and the settings in which they live commensurate with their needs and level-of-care determination. • Case management standards support planning that promotes the least restrictive, most appropriate setting in accordance with needs and preferences. • Assisted Living Residences assume a person will age in place and only allow for termination of services in specific circumstances.			
(d) Include a clear description of the condition that is directly proportionate to the specific assessed need	**CFC Regulations** Sec. IV. B 1, B 2 Sec. VII. B 5, B 6 Sec. XI	• CFC participants in the High and Highest Needs groups all meet nursing facility level of care, but may choose to receive care in less restrictive settings; changes to a more restrictive nursing facility care would be by choice or as medically directed. • Changes are by participant choice or as medically directed. • Variance request must include a description of the need, explanation of why the need cannot be met, and a description of the actual or immediate risk to health, safety, or welfare of the participant. • CFC Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Silent	Silent	Silent
(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification	**CFC Regulations** Sec. XI. D	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • CFC Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Silent	Silent	Silent
(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated	**CFC Regulations** Sec. XI	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • CFC Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Silent	Silent	Silent
(g) Include informed consent of the individual	**CFC Regulations** Sec. XI	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders.	Partial	Partial	Alignment

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HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
		• Adult Family Care Agreements include a consent. • Variance requests do not specify informed consent; however, they are permissive of DAIL's requiring any additional detail needed to address the request. • Adult Day Standards require informed consent in planning processes.	Documentation requirements could be stronger	Documentation requirements could be stronger	
(h) Include an assurance that interventions and supports will cause no harm to the individual	**CFC Regulations** Sec. XI **Residential Care Home Licensing Regulations** Sec. III, Sec. V. 5.3 **Assisted Living Residences Licensing Regulations** Sec. 4, 6.5	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • CFC Regulations and operations manuals include requirements for the protection of health and safety and are permissive of DAIL's requiring any additional detail needed to address the request.	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger

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Appendix B: Person Centered Planning Requirements and Vermont Regulation and Policy Crosswalk

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
1. Includes people chosen by the individual and led by person or legal rep where possible	**Choices for Care Regulations** Sec. VII. B 5 **CFC Program Manual** Sec. III. C 7 **Case Management Standards & Certification Procedures** Sec. IV. B, C, G, H, I **Case Management Action Plan Guide** **Standards for Adult Day Services** Sec. I. A, B Sec. X. A, B Sec. XI. D4	• CFC Regulation calls for person-centered planning and defines it as a process by which services are planned and delivered based on an individual's strengths, capacities, preferences, needs, and desired outcomes. • DAIL Case Management Certification Standards and the DAIL Case Management Action Plan Guide call for members of the person's choosing to be involved in the planning process as directed by the participant or legal guardian.	Alignment	Alignment	Alignment
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	**Choices for Care Regulation** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C. **Case Management Standards & Certification Procedures** Sec. IV. A, B, C **CFC Program Manual** Sec. III. C 7 Section IV. 10, 11 E 1 **Adult Family Care Participant Rights**	• CFC regulations provide that persons receive information on all options available within the Choices for Care Program. • DAIL Clinical Care staff is required to discuss all available long-term care options as part of the application process. • DAIL Case Management Certification Standards and the DAIL Case Management Action Plan Guide call for participants to receive timely information and referral information and assistance in the service planning and monitoring process to ensure that needs are being met and goals pursued.	Alignment	Alignment	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Adult Family Care Service Plan (Consent Statement regarding options)				
3. Is timely, occurs at times and locations of convenience to the individual	**Case Management Standards & Certification Procedures** Sec. IV. F, I **Case Management Action Plan Guide**	• Case Management Certification Standards call for timely response to participants and for initial goals and objectives to be in place within 60 days of the participant's assessment. • Case Management Action Plan Guide does not address location.	Partial Guidance discusses participant direction but does not specify time and location arrangements	Partial Guidance discusses participant direction but does not specify time and location arrangements	Partial Guidance discusses participant direction but does not specify time and location arrangements
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	**Case Management Standards & Certification Procedures** Sec. IV. A, B, C, G, I **Case Management Action Plan Guide** **AHS Limited English Proficiency Policy** **Standards for Adult Day Services** Sec. I A, B Sec. X A, B Sec. XI D4 Sec. XII D2-5	• Case Management Certification Standards require service plans to respect participants' rights, strengths, values, and preferences and encourage them to create, direct, and participate in their written plan to the fullest extent possible. • Case Management Action Guide calls for plans to be written in 'Plain English' using terms and language that the participant can understand. • All units of government within the Agency of Human Services are also required to follow the Agency's policies and practices on assuring services are provided in an accessible manner for participants who have Limited English Proficiency.	Alignment	Alignment	Alignment
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	**CFC Regulations** Sec. II. F; Sec. XII; Sec. XIII. B 2-4, C 3-5 **CFC Program Manual** Sec. III. C 5, C 6, C 16, C 18	• CFC regulations call for a process for handling participant feedback, complaints, and disagreements. • CFC Universal Provider Standards and Case Management Certification Procedures require all providers to have conflict-of-interest procedures and to make those processes known to participants.	Alignment	Alignment ERC specific conflict of interest standards could be strengthened due to the nature of the all-inclusive package.	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Case Management Standards & Certification Procedures Sec. III. B, K Sec. IV. L, M **Standards for Adult Day Services** Sec. IX. D	• The CFC grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration. • Standards for Adult Day Services include requirements for conflict of interest.			
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, *except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and*	**CFC Regulations** Sec. XII Sec. XIII. B 2, B 3, B 4, B 5 **CFC Program Manual** Sec. III. C 5, C 6, C 16, C 18 **Case Management Standards & Certification Procedures** Sec. III. B, K Sec. IV. L, M **MCO Grievance and Appeal Rules**	• VT Statute provides for the designation and certification of Home Health Agencies, Area Agencies on Aging to serve specific geographic regions and populations. Participants may choose where to receive their case management services from among approved providers and may choose a single agency for all services. • VT Statute requires a Long-Term Care Ombudsman program. • DAIL has established Aging and Disability Resource Centers statewide for information and referral, options counseling, and assistance with understanding grievance and appeal rights. • VT legislature recently directed DAIL to eliminate potentially duplicative functions for persons receiving case management as part of all-inclusive Adult Family Care or Enhanced Residential Care services, and additional case management services from an AAA or Home Health provider. • CFC Universal Provider Standards and Case Management Certification Procedures require all providers to have conflict-of-interest procedures and to make those processes known to participants. • Participants choosing Adult Family Care receive case management from a host agency. The host agency is responsible for facilitating an acceptable match of shared living setting, contracting with the home provider on the participant's behalf, and developing a person-	Alignment	Partial Due to nature of the all-inclusive payment, persons who choose these living options are also choosing an all-inclusive service package that includes case management.	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
provider functions within provider entities, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*		centered plan between the home provider and the recipient. The host agency is responsible for oversight of the care plan and following up on any client concerns with the home, plan, or other services. • Participants choosing ERC in a Residential Care Home or Assisted Living Residence receive an all-inclusive package of services that includes case management from the provider. • CFC regulations require a quality assurance/quality improvement process that includes provisions for a Long-Term Care Ombudsman; participant complaints, appeals, fair hearings, and feedback to DAIL; and provider performance monitoring. • The CFC grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration. • Case Managers cannot be financially responsible or related to the person.			
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	**Choices for Care Regulations** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C. **Case Management Standards & Certification Procedures** Section IV. A, C **CFC Program Manual** Sec. III. C 7 Sec. IV. 11, E **Adult Family Care Training Materials** Goal and General Policies;	• All Participants choose where to receive their long-term services and supports. • DAIL Clinical Care Coordinators are responsible for ensuring that recipients have made informed choices regarding where and from whom they receive services. • Adult Family Care host agencies are responsible for facilitating a person-centered plan between the home provider and the recipient that address all aspects of shared living and service provision. • CFC also offers self-management of services under the Flexible Choices option.	Alignment	Alignment	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Sec. 1. b-c; 2 b **Adult Family Care Participant Rights** **Adult Family Care Service Plan** (Consent Statement)				
8. Includes a method for the individual to request updates to the plan as needed	**Case Management Standards & Certification Procedures** Sec. IV. B, F, G, I **Case Management Action Guide**	• Case Management Certification Standards call for case managers to provide timely response to participants' requests for assistance and to monitor progress and update participants' plans as needed and no less than annually. • The Certification Procedures and Action Guide require the regular review and updating of the plan as needed but do not specifically mention participant-initiated change.	Alignment	Alignment	Alignment
9. Records the alternative home- and community-based settings that were considered by the individual	**Adult Family Care Service Plan** (Consent Statement)	• CFC regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making; however, how and where documentation should occur is not specifically mentioned. • DAIL Case Management Action Plan Guide calls for the action plan to document the person's preferences, long- and short-term goals, and plans to address those goals. • Adult Family Care Service Plan includes consent and signature line noting that the participant was informed of all options.	Alignment	Alignment Documentation could be strengthened	N/A
10. Reflect that the setting in which the individual resides is chosen by the individual.	**CFC Regulations** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f), A 2 (b), (c), (g); C **CFC Program Manual** Sec. III. C 7 Sec. IV. 11, D 8, E	• CFC regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making; however, how and where documentation should occur is not specifically mentioned. • DAIL Case Management Action Plan Guide calls for the action plan to document the person's preferences, long- and short-term goals, and plans to address those goals.	Partial Documentation could be strengthened	Partial Documentation could be strengthened	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Case Management Standards Certification Procedures Sec. IV. C **Adult Family Care Service Plan** (Consent Statement)				
11. Reflect the individual's strengths and preferences	**Case Management Standards & Certification Process** Sec. IV. B, G, H, I, K	• CFC regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making; however, how and where documentation should occur is not specifically mentioned. • DAIL Case Management Action Plan Guide calls for the action plan to document the person's strengths, preferences, long- and short-term goals, and plans to address those goals.	Alignment	Alignment	Alignment
12. Reflect needs identified through functional assessments	**CFC Regulations** Sec. IV. B, C; Sec. V. C, D; Sec. VI; Sec. VII. B 1, B 3, B 5, B 6 **CFC Program Manual** Sec. IV. 11 D 8 **Case Management Standards & Certification Procedures** Sec. IV. B, G, H, I, J, K **Case Management Action Plan** **Standards for Adult Day Services** Sec. XI. D4	• CFC regulation and certification standards provide for service and person-centered plans to be based on functional assessments, strengths, preferences, and supports that maximize independence.	Alignment	Alignment	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
13. Include individually identified goals and desired outcomes	**Case Management Standards & Certification Process** Sec. IV. H, I, J, K **CFC Program Manual** Sec. IV. 11 D 8 **Adult Family Care Training Materials** **Case Management Action Plan** **Standards for Adult Day Services** Sec. XI D4	• Case Management Certification Standards and Case Management Action Guide call for plans to reflect short- and long-terms goals and actions steps, persons responsible, and target dates.	Alignment	Alignment	Alignment
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	**Case Management Action Plan** **Standards for Adult Day Services** Sec. XI. D4	• Case Management Certification Standards and Case Management Action Guide call for plans to reflect short- and long-terms goals and actions steps, persons responsible, and target dates. • Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan.	Alignment	Alignment	Alignment
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	**Case Management Standards & Certification Procedures** Sec. IV. B 3, K 9 **Assisted Living Licensing Regulations** Sec. IX. Negotiated Risk **Standards for Adult Day Services**	• Case Management standards call for person-centered plans to address all needs and also call for assessment of acceptable risk and written agreements as needed. • Assisted Living Licensing Standards provide for Negotiated Risk Agreements as needed.	Alignment	Alignment	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Sec. IV. A Sec. XI. D4				
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	**Case Management Action Plan Guide** **AHS Limited English Proficiency Policy**	• Case Management Action Guide calls for plans to be written in 'Plain English' using terms and language that the participant can understand. • All units of government within the Agency of Human Services are also required to follow the Agency's policies and practices on assuring services are provided in an accessible manner for participants who have Limited English Proficiency.	Alignment	Alignment	Alignment
17. Identify the individual and/or entity responsible for monitoring the plan	**Case Management Action Plan Guide**	• Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan.	Alignment	Alignment	Alignment
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	**Case Management Action Plan Guide**		Alignment	Alignment	Alignment
19. Be distributed to the individual and other people involved in the plan	**Case Management Action Plan Guide**	• Case Management Action Plan calls for distribution to the participant and members of the planning team and/or family with the participant's consent.	Alignment	Alignment	Alignment

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Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
20. Include those services, the purpose or control of which the individual elects to self-direct	**Case Management Action Plan Guide** **CFC Program Manual** Sec. IV. 10	• Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan. • CFC Flexible Choices provides for additional guidance regarding self-directed care options.	Alignment	Alignment	Alignment
21. Prevent the provision of unnecessary or inappropriate services and supports	**CFC Regulations** Sec. VII. B 6 **CFC Program Manual** Sec. III. C 4, C 8, C 17 Sec. IV. 8 E Sec. IV. 11 I	• CFC Program manual requires providers to ensure services are coordinated and responsive to the individual's needs and are not duplicative or unnecessary.	Alignment	Alignment	Alignment
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual	**Case Management Standards & Certification Procedures** Sec. IV. B, F, G, I **Case Management Action Guide** **Residential Care Home Licensing Regulations** Sec. 5.7, 5.9(c) **Assisted Living Residence Licensing Regulations** Sec. 6.7	• Case Management certification standards and action plan guide note that plans are required to be reviewed as needed or requested by the participants, but no less than annually. • Residential and ERC licensing standards require assessments, plans, and review, but do not specify periodicity.	Alignment	Alignment	Alignment
Modifications to any of the home and community setting requirements are documented: See settings rule crosswalk in Appendix A.					

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