

Participant Review Sheet						HCBS CQS	July 2018	000977
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					

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	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 who 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 inclusive, person-centered process that enables the adult day center to serve the participant to the best of its ability. The initial POS shall be written within ninety (90) days from the beginning of adult day services.	Participant records, discussion with Participants and staff					

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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					

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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.					

Certification Review Sheet

HCBS CQS July 2018 000981

Date of Site Assessment	
Certification or Special Assessment:	Recertification
Adult Day Center (Site):	
Parent Organization:	
Adult Day Administrator:	
Adult Day Program Coordinator:	
DAIL Staff:	Stuart Senghas MSW

	Reference	Standard	How Reviewed	Comments and Findings	Met	Unmet
		The Adult Day Center shall provide and demonstrate the following:				
	III.A, B & C	The center has a governing body.	DAIL staff review at the site visit.			
	III.D	The governing body has developed 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.	DAIL staff review at the site visit.			
	III.E	The governing body shall meet at least quarterly. Agendas and minutes shall be on file at the adult day center to verify times, content, and attendance for each meeting.	Review of copies of governing body minutes and agendas. For centers that are part of larger organizations, just the agendas and minutes for meetings where the Adult Day program was discussed.			

	IV.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 CFC and Day Health and Rehab. Services.) and the Outcomes for Adult Day Programs established by the Dept.	Document review, site observation, and staff discussions.	HCBS CQS July 2018 000982		
	IV.B	The QA/I 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.	Discussion with participants, staff and director. Review of program calendars.			
	IV.C+D	The QA/I process shall include a regular review of the programs alignment with the applicable federal HCBS rules regarding settings and person-centered planning.	Document review, site observation, and staff discussions.			
	IV.E	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.	Documentation of solicitation of feedback from stakeholders and a summary of that feedback.			
	V.A	There shall be a written, dated job description for each staff position that specifies at least job qualifications, job responsibilities and line of supervision.	Review of job descriptions of each employee positions.			

	V.B	An adult day center shall have a qualified administrator and/or program coordinator who is responsible for meeting and maintaining continual compliance with the <u>Standards for Adult Day Services in Vermont</u> and all relevant federal, state, local or municipal laws, regulations, policies, and/or procedures.	Review of the name's and qualifications of the individual's responsible for administration and/or program coordination. Review at the site visit.	HCBS CQS July 2018 000983		
	V.C.3	A qualified staff member has been designated to supervise the center in the absence of the person responsible for administration/program coordination.	Discussion with Director at site visit regarding process of how staff are made aware of the staff member designated to supervise the center in the absence of the person responsible for administration/program coordination.			
	V.D	If the adult day center shares a facility with another, non-adult day program or service, they have dedicated staff with hours that are committed to the adult day center only AND documentation is on file verifying which staff members are committed to the Adult Day Center only.	Review of duty rosters or assignment sheets available which show how shared staff are assigned to the Center.			
	V.E	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.	Review of documentation showing completion of background checks and supervision/oversight of the individual. Including contract or letter of agreement if available.			
	V.E.2	The adult day center shall maintain a written contract on file at the center with each paid contractor or consultant.	Please have written contracts available.			
	VI.A	Written personnel policies shall be adopted and kept on file at the center.	Review of policies at site visit.			
	VI.B & D	Documentation shall be on file at the center showing that all staff currently meets the minimum qualification needed for their job and have passed required background checks and licenses.	Review of relevant information from personnel files for all staff at first review and for new hires for the annual review.			

	VI.C	An adult day center shall comply with the mandated reporting of abuse, neglect and exploitation pursuant to Vermont State Law.	Review of information and center's policy in the orientation packet for new employees, and reviewed annually for all employees. Discussion with staff.	HCBS CQS July 2018 000984		
	VI. E & F	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.	Site review of documentation of orientation and ongoing training(s).			
	VII.	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.	Review of the following policies:			
			Smoking policy for staff and participants			
			Infection control			
			Emergency Evacuation Plan			
			Conflict of Interest Policy			
			Record Retention Policy			
			Confidentiality of Participant Records			
			Visitor policy			
	VIII.	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 and others included in section X of the Standards.	Review of the following policies:			
Electronically Submit (if possible)			Non-discrimination Policy			
			Participants' Rights Policy - show it is posted			
			Enrollment Policy			
			Advance Directive Policy			
			Medical Emergency Policy - Show it is posted			
			Medication Administration Policy			
			Restraint Policy			
			Incident Policy			
			Emergency Closing Policy			
			Grievance Policy			
			Involuntary Discharge Policy			

	X.B	Assistance with and supervision of Activities of Daily Living (ADLs) in a safe and hygienic manner; with recognition of the participants' dignity and right to privacy; and in a manner that encourages the maximum level of independence.	Observation and discussion with staff and participants.	HCBS CQS July 2018 000985		
	X.C	Center offers support to participants and family in identifying and using community resources as needed.	Discussion with participants, staff and director.			
	X.D.1-3	A structured program plan of activities is available and posted daily to assist with orientation. Program activities are available to all program participants. Participants are encouraged to take part in activities, but may choose not to do so or may choose another activity.	Review of monthly activity plans and discussions with staff and participants.			
	X.D.4	Participants shall be allowed time for rest and relaxation and to attend to personal and health care needs.	Observation and discussion with staff and participants			
	X.D.5-9	Activity programming that meets the required standards is available during all hours of operation and is provided in an environment conducive to facilitating activities. Participants shall be assisted in maintaining maximum mobility and independence.	Observation and discussion with staff and participants			
	XI.B.1	Each meal served provides 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 also complies with the Dietary Guidelines for Americans.	Site review of menus available for the last month.			
	XI.B.2	To the maximum extent possible, special diet needs were accommodated.	DAIL staff will review on site including review of participants			

	XI.A.4&5	The current monthly menu was posted in a place accessible and visible to all participants and other interested parties. The center follows the written, posted menus. If a substitution was made, the substitution was recorded on the written menu or a menu substitution sheet.	DAIL staff will review on site.	HCBS CQS July 2018 000986		
	XI.B.3	Center has adequate emergency food supplies appropriate to their site.	DAIL staff will review on site			
	XI.D.2	Nourishing snacks are available to participants between meals.	Site review of the last two months of snack menus.			
	XI.D.3	Participants are allowed an adequate amount of time to eat each meal at an unhurried pace.	DAIL staff will review on-site.			
	XI.D.5	Participants are provided with assistance in eating, as needed, by properly trained staff.	DAIL staff will review on-site.			
	XI.E	The center's food handling and storage techniques are consistent with safe food handling practices.	DAIL staff will review on-site.			
	XII.A.2	Adult day services are offered to participants a minimum of five (5) days per week, nine (9) hours per day at the primary adult day center site.	Site review including literature which shows hours of operation available.			
	XII.E.3	The center meets all of the applicable fire safety and building requirements.	DAIL staff will review on site.			
	XII.F.1	The center has a sign outside clearly identifying the name of the adult day center.	DAIL staff will review on site.			
	XII.F.2	The center is 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.	DAIL staff will review on site.			
	XII.F.11	Emergency first-aid kits shall be available in the program area.	DAIL staff will review on site.			

	XII.G.4.a	At least sixty (60) square feet of program space for each participant. 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.	DAIL staff will review on site.	HCBS CQS July 2018 000987		
	XII.G.4.b	Sufficient flexibility and adaptability for large and small groups, and for individual activities and services.	DAIL staff will review on site.			
	XII.G.4.c	Sufficient private office space to permit staff to work effectively and without interruption.	DAIL staff will review on site.			
	XII.G.4.e	At least one toilet for every 10 participants, easily accessible from all areas.	DAIL staff will review on site.			
	XII.G.4.f	Areas separate from program space that provide sufficient space for a rest area, for special therapies, for privacy, and for isolating participants who become ill.	DAIL staff will review on site.			
	XII.G.4.h	Outdoor space that is used for outdoor activities shall be safe, accessible to indoor areas, and accessible to those with a disability.	DAIL staff will review on site.			

The Agency of Human Services and the All-Payer Model

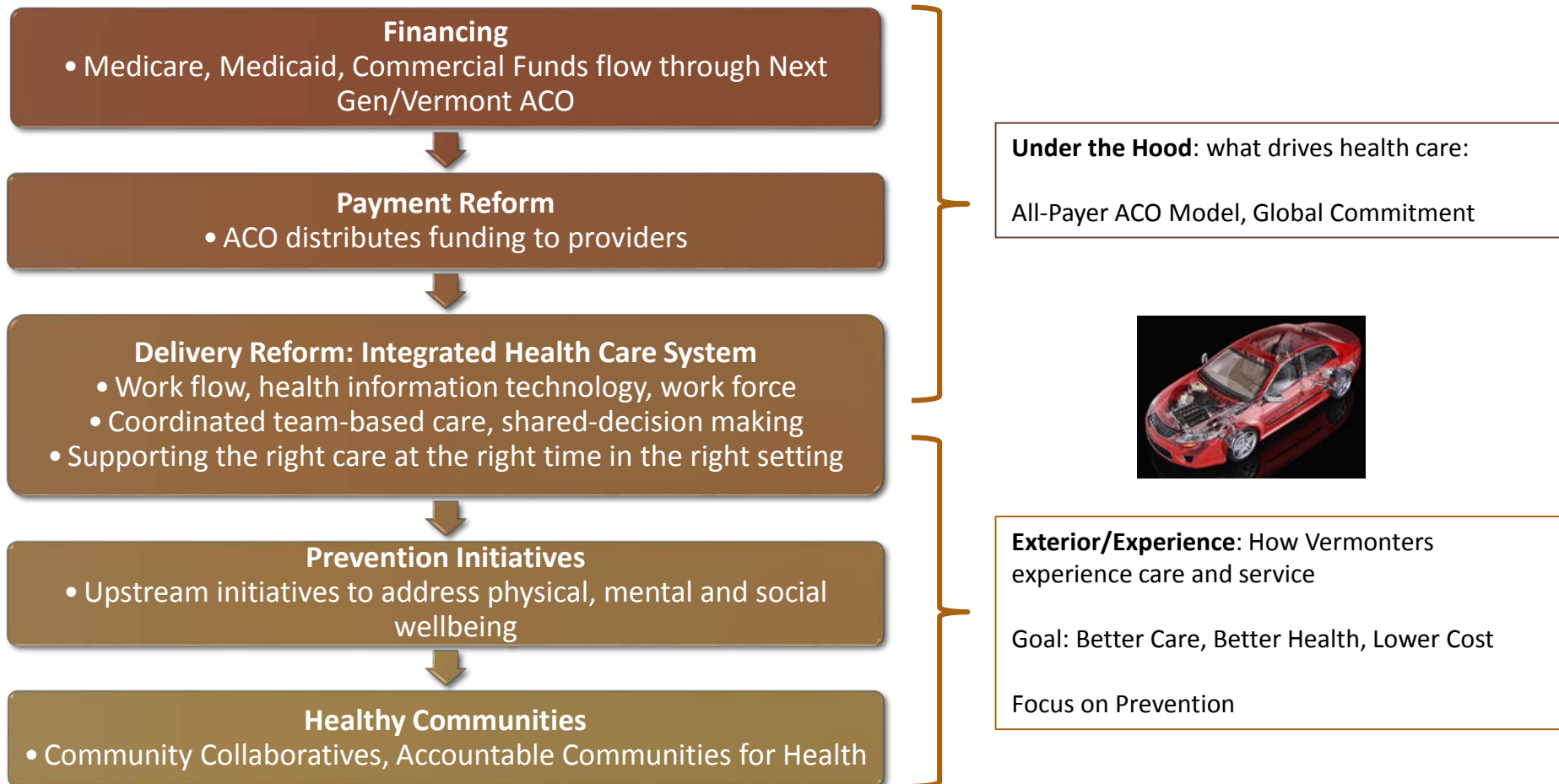
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1. Strategic Alignment



GPS Health Care Reform Plan



AHS Strategic Plan: 2018 Goals

- 1. Manage cases better together.** By 2019, standardize and improve case coordination and planning to improve client service and outcomes.
- 2. Increase access.** By 2019, analyze AHS enrollment and eligibility policies and processes to increase access to services and supports.
- 3. Informed decision-making.** By 2019, implement data governance to assess the value and impact of AHS programs and services. By 2020, implement governance, planning, and change processes to analyze and prioritize business improvement and automation projects across AHS.
- 4. Maximize return on investment.** By 2019, design and implement value-based payment models to incent quality and outcomes for providers of *identified AHS programs and services*. By 2020, design and implement a process to increase evidence-based programming *throughout AHS*.
- 5. Support community services.** By 2019, assess regional utilization of facilities and access to *identified home and community-based services*. By 2020, implement a plan to improve flow across service systems and levels of care.

Delivery System Reform Goals

Vermonters deserve health and high quality high value care

- 
1. Integrate services across traditional health care and community based providers.
 2. Move the current fee for service healthcare system to value based payments.
 3. Ensure that value based payments are multi-payer, aligned and integrated.
 4. Invest in and link payment reforms with delivery systems goals to achieve outcomes.
 5. Monitor outcomes and use to direct future actions.
 6. Shift funding into population health and prevention.

APM Goal Alignment

All-Payer Model Goals are based on Vermont's Population Health Goals, which align with the Governor's prevention focused agenda:

- Behavioral Health Services (2017 – 2018)
 - Mental Health
 - Substance Use Disorders
- Community Health Services (2017 – 2018)
 - Rise Vermont 3-4-50
 - Nurse Home Visiting Program
 - Blueprint CHT
- Future: Home and Community Based Services (~Choices for Care)

APM Alignment with Prevention Vision

All-Payer Model

Governor's Priorities & Current Work

Behavioral
Health Services

Mental Health Reform
Multi-Payer Substance Use Disorders

Community
Health Services

Rise Vermont 3-4-50
Nurse Home Visiting Program
Children's Oral Health

Medicaid ACO

Medicaid Next Generation ACO Program

2017 - 2018

2. AHS Roles in the All-Payer Model

All-Payer Model Description

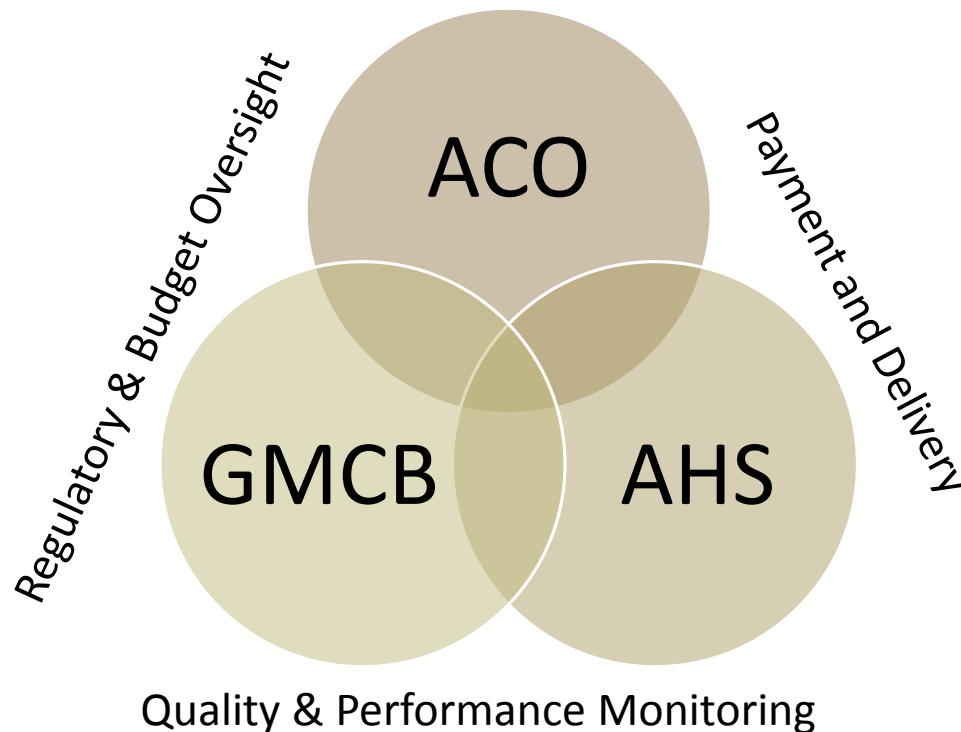
The All-Payer Model is a tool to help Vermont achieve broad health reform goals. It changes the State's relationship with the Centers for Medicare and Medicaid Services.

1. The **all-payer Model** is an agreement between the State and the Center for Medicare and Medicaid Services that allows Vermont to explore new ways of financing and delivering health care.
2. The primary finance vehicle in the all-payer model agreement is the **Next Generation ACO program** which allows ACOs to be paid an all-inclusive population-based payment for each beneficiary attributed to the ACO in lieu of fee for service payments; moving toward value based payments and capping the growth in the total cost of care for Vermonters at 3.5%.
3. The all-payer model allows CMS to modify their traditional Next Generation ACO program, enabling the three main payers of health care in Vermont – **Medicaid, Medicare, and commercial insurance, to align.**
4. The All-payer Model also allows Vermont to request additional waivers of CMS rules and gives ACOs participating in the Next Generation Program flexibility in certain payment rules.

AHS Responsibilities

1. Implement the **Medicaid Next Generation ACO** Program
2. Develop a plan to coordinate the financing and delivery of Medicaid **Behavioral Health Services** with the All-Payer Model financial targets
3. 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.
4. Develop a plan to coordinate the financing and delivery of Medicaid **Home and Community Based Services** with the All-Payer Model financial targets
5. Add Medicaid Long-Term Institutional Services in All-payer Financial Target Services for Performance Year 4 and Performance Year 5.

Key Relationships

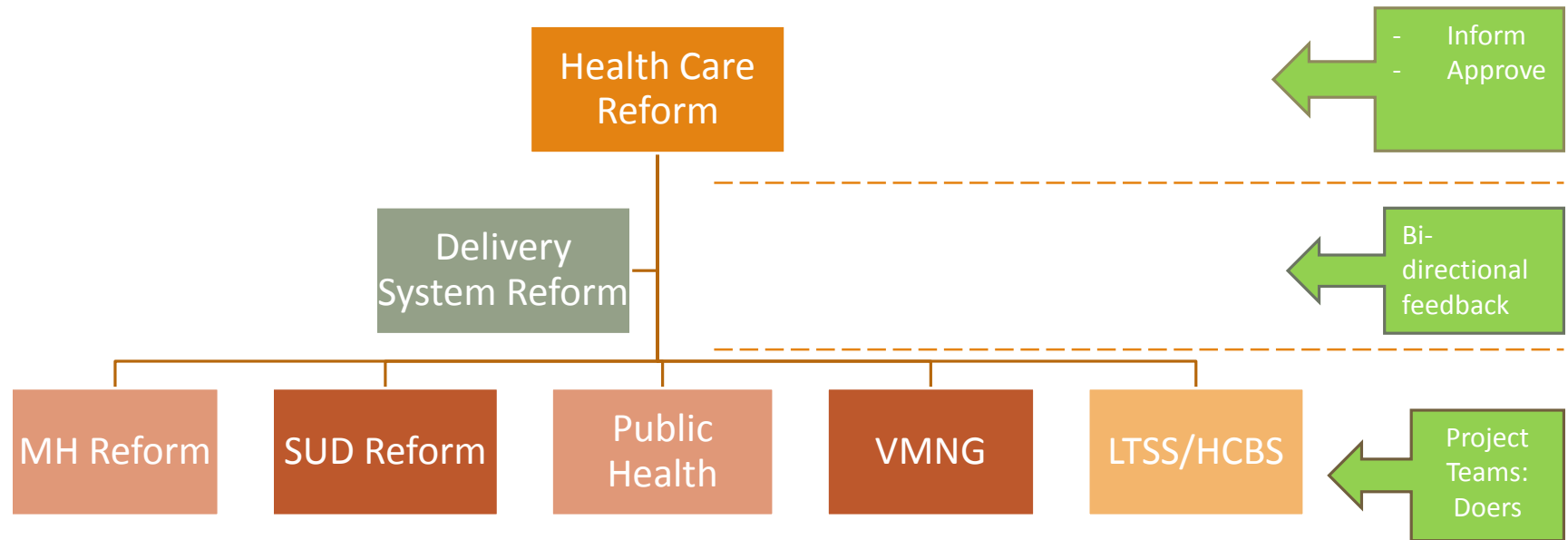


Others: Legislature, Centers for Medicaid and Medicare Innovation, Payers

3. Organization of Work



Work Group Structure



Cross Agency Reform Planning

2017

- Vermont Medicaid Next Gen. Contract 2018
- Vermont Medicaid Next Gen. Design 2019
- Substance Use Disorder Design
- Mental Health Design
- Community Health Services Design
 - Rise Vermont 3-4-50 Expansion Planning
 - Universal Home Visiting Design
 - Blueprint for Health & ACO Partnership

Cross Agency Reform Planning

2018

- Vermont Medicaid Next Gen. Contract 2019
- Vermont Medicaid Next Gen. Design 2020
- Mental Health Design
- Substance Use Disorder Design
- Community Health Services Design
 - Rise Vermont 3-4-50
 - Universal Home Visiting
- Align APM and AHS Priorities to Identify 2019 Systems Design Work

2019

- Vermont Medicaid Next Gen. Contract 2020
- Vermont Medicaid Next Gen. Design 2021
- System Design - LTSS

4. Discussion

1. Does this presentation adequately frame the work and the roles of AHS in regards to delivery and payment reform?
 - What works well?
 - What is missing?
2. Reflecting on the workgroup structure-
 - Do the project teams reflect your current reality?
 - Is the DSR role, as described, appropriate and the best use of that group's time?
3. Other?

First Name	Last Name	Email	Provider Name	HCBS Service
Linda	Wichlac	Linda.Wichlac@bpiads.org	Bennington Project Independence	Adult Day
Sue	Chase	sue@carepartnersvt.org	CarePartners Adult Day Services	Adult Day
Joanne	Corbett	mail@elderlyservices.org	Elderly Services, Inc.	Adult Day
Judy	Santamore	jsantamore@giffordmed.org	Gifford Medical Center Adult Day Center	Adult Day
Linda	Thayer	gmads@sover.net	Green Mountain Adult Day Services of Orleans Count	Adult Day
Loryn	Hamilton	lham802@aol.com	Interage Adult Day Services	Adult Day
Peter	Coutu	rllec@sover.net	Lamoille Day Health Services	Adult Day
Julia	O'Donnell	osipads@gmail.com	Oxbow Senior Independence Program	Adult Day
Peter	Coutu	rllec@sover.net	Riverside Life Enrichment Center	Adult Day
JoAnne	Bohen	JBohen@springfieldmed.org	Springfield Area Adult Day Services	Adult Day
Mary	Fredette	info@gatheringplacevt.org	The Gathering Place	Adult Day
Jennifer	Barnes	jennifer.barnes@nekhc.com	The Meeting Place	Adult Day
Diane	Olechna	olechna@vnacares.org	VNA Adult Day Program	Adult Day
Brent	Hewey	BHewey@ccs-vt.org	Champlain Community Services	Adult Family Care
Alysia	Chapman	AlysiaC@howardcenter.org	Howard Center	Adult Family Care
Bart	Mair	BMair@lincolnstreetinc.org	Lincoln Street Inc.	Adult Family Care
Cindy	Cook	CCook@nkhs.net	Northeast Kingdom Human Services	Adult Family Care
William	Ashe	billa@uvs-vt.org	Upper Valley Services	Adult Family Care
Nicole	Pierce	npierce@hotmail.com	Choice TBI Support Services, Inc.	Adult Family Care
Jennifer	Murdoch	JMurdoch@csac-vt.org	Counseling Services of Addison County	Adult Family Care
David	Wheeler	David@familiesfirstvt.com	Families First Southern Vermont	Adult Family Care
Marilyn	Carter	marilync@sterlingarea.org	Green Mountain Support Services	Adult Family Care
Katie	Gilcris	mgilcris@hcrs.org	Health Care and Rehabilitation Services of Southeastern Vermont	Adult Family Care
Kevin	Burke	lennyburkesfarm@gmail.com	HIS Independence Project, Inc.	Adult Family Care
Amber	Schaeffler	amber.schaeffler@ncssinc.org	Northwestern Counseling and Support Services	Adult Family Care
Kim	Daniels	kdaniels@tds.net	PRIDE, Inc.	Adult Family Care
Michael	Kersten	mkersten@rmhscn.org	Rutland Mental Health Services, Inc.	Adult Family Care
Kathy	Hamilton	khamilton@ucsvt.org	United Counseling Services	Adult Family Care
Michael	Hall	jmh@cva.org	Age Well	Case Management
Beth	Stern	bstern@cvcoa.org	Central VT Council on Aging	Case Management
Meg	Bermeister	mburmeister@nekcouncil.org	Northeastern Vermont Area Agency on Aging	Case Management
Carol	Stamatakis	cstamatakis@seniorsolutionsvt.org	Senior Solutions	Case Management
Sandy	Conrad	sconrad@svcoa.net	Southwestern Vermont Council on Aging	Case Management
Sherry	Greifzu	sgreifzu@achhh.org	Addison County Home Health and Hospice	Case Management
Sandy	Rousse	srousse@cvhhh.org	Central VT Home Health and Hospice	Case Management
Janet	McCarthy	jmccarthy@fchha.org	Franklin County Home Health Agency	Case Management
Kathleen	Demars	kdemars@lhha.org	Lamoille Home Health	Case Management
Barbara	Keough	mhs.inc@comcast.net	Manchester Health Services	Case Management
Treny	Burgess	trenyb@nchcv.org	Caledonia Home Health Care	Case Management
Lyne	Limoges	lilimoges@oevna.org	Orleans-Essex VNA & Hospice, Inc.	Case Management
Ron	Cioffi	rcioffi@ravnah.org	Rutland Area Visiting Nurse Association and Hospice	Case Management
Jeanne	McLaughlin	jmclaughlin@vnavnh.org	Visiting Nurse Association and Hospice of VT/NH	Case Management

Judy	Peterson	peterston@vnacares.org	Visiting Nurse Association of CBS CQS Chittenden and Grand Isle Counties	July 2018 001006 Case Management
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First Name	Last Name	Email	Provider Name	HCBS Service
Earl	Whitmore	ewhitmoreeef@gmail.com	Eagle Eye Farm	TBI
Linda	Ormsbee	lormsbee@comcast.net	Choice TBI Support Services, Inc.	TBI
Jennifer	Murdoch	jmurdoch@csac-vt.org	Counseling Services of Addison County	TBI
Katie	McCarthy	katie@familiesfirstvt.com	Families First Southern Vermont	TBI
Sonja	Crowe	sonjaC@GMSSI.org	Green Mountain Support Services	TBI
Katie	Gilcris	mgilcris@hcrs.org	Health Care and Rehabilitation Services of Southeastern Vermont	TBI
Kevin	Burke	B1840house@aol.com	HIS Independence Project, Inc.	TBI
Scott	LaValley	scott.LAVALLEY@ncssinc.org	Northwestern Counseling and Support Services	TBI
Joan	Carman	joan.carman@uvs-vt.org	Upper Valley Services Inc.	TBI
Michele	Corrow	mcorrow@pridetbi.com	PRIDE, Inc.	TBI

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

Provider Program		Total #		May-18		HCBS	
Provider	Type	AFC	TBI	AD	Consumers	15%	NCI Survey
		Validation Status		HCBS CQS July 2018 001010			
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
ChampCommServ	SSA	3			3	0	1
CSAC	DA	7			7	1	2
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
OEVNA	HHA				0	0	14
Oxbow	AD				0	0	
PRIDE	TBI	18	28		46	7	8
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				

met May 2018

met May 2018

met May 2018

met May 2018

66
0.1679
1755

Estimate As of November 17, 2017

Service Totals		#	15% Sample	# of 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)

Provider Program		Total #		May-18		HCBS	
Provider	Type	AFC	TBI	AD	Consumers	15%	NCI Survey
		Validation Status					
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CarePartners	AD				0	0	
CHHC	HHA				0	0	8
CHOICE	TBI	9	25		34	5	19
ChampCommServ	SSA	3			3	0	1
CSAC	DA	7			7	1	2
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	
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GMSS	SSA	24	9		33	5	
HCRS	DA	1	2		3	0	
HISIP	TBI		7		7	1	
Howard Center	DA	2			2	0	1
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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
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PRIDE	TBI	18	28		46	7	8
Randolph	AD				0	0	
RAVNAH	HHA				0	0	31
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Section	Topic	Milestone
I	Systemic Assessment and Remediation	
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		Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.
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		Implementation of new rules and regulations: 50% complete
		Implementation of new rules and regulations: 100% complete
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III	Site-specific Remediation ¹	This section includes only those providers where remediation was required.

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Completion of nonresidential provider
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Completion of nonresidential provider
2b remediation: 50%

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3 Identification of settings that will not
remain in the HCBS System

IV Heightened Scrutiny²

The first three heightened scrutiny
milestones should be completed prior to
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1 provider

Complete gathering information and
evidence on settings requiring heightened

2 scrutiny that it will present to CMS

Incorporate list of settings requiring
heightened scrutiny and information and
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Submit STP with Heightened Scrutiny

4 information to CMS for review

V Relocation

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2 Complete beneficiary relocation across all providers.

Complete beneficiary relocation across all
2a providers: 25%

Complete beneficiary relocation across all
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Complete beneficiary relocation across all
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Description	Proposed Due Date	CQS/STP Page No.
Complete crosswalk of state regulations compared to new federal HCBS requirements (scored as alignment, partial alignment, silent, or non-compliant)	Completed	Page 10; Appendix E
<p>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.</p> <p>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.</p>		<p>Page 10; Appendix E</p> <p>Appendix E</p> <p>Appendix E</p>
Determine settings ability to accommodate new HCBS requirements (with scoring outcomes/results)		<p>Page 13 Site Specific Settings Assessments Add to CQS Page 13 Site Specific Settings Assessments or Page 27 Public Engagement Pending</p>
Share site specific settings assessment and validation plan with external stakeholders		Page 13 Remediation Strategies

Pending

[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.]

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**Add Section Page 14
Provider Removal**

Identify process and settings presented for heightened scrutiny – if necessary.

**Page 14 Heightened
Scrutiny Plan and Process**

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**Page 15 Relocation Plan
and Process**

[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.]

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**Page 15 Relocation Plan
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[The date when beneficiaries in all providers have been relocated. Please provide additional details on settings in the description.]

Comments

The state has completed the systemic assessments, including review of all rules, regulations, and statutes

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Section	Title	Milestone
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Description	Proposed Due Date	CQS/STP Page No.
Complete crosswalk of state regulations compared to new federal HCBS requirements (scored as alignment, partial alignment, silent, or non-compliant)	Completed	Page 10; Appendix A
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Determine settings ability to accommodate new HCBS requirements (with scoring outcomes/results)		<p>Page 13 Site Specific Settings Assessments Add to CQS Page 13 Site Specific Settings Assessments or Page 27 Public Engagement Pending</p>
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Provider Removal**

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Scrutiny Plan and Process**

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**Page 15 Relocation Plan
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Description	Proposed Due Date	CQS/STP Page No.
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**Page 15 Relocation Plan
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V Relocation

1 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.

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

1a relocation is required: 25%

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

1b relocation is required: 50%

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

1c relocation is required: 75%

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

1d relocation is required: 100%

2 Complete beneficiary relocation across all providers.

Complete beneficiary relocation across all
2a providers: 25%

Complete beneficiary relocation across all
2b providers: 50%

Complete beneficiary relocation across all
2c providers: 75%

Complete beneficiary relocation across all
2d providers: 100%

Description	Proposed Due Date	CQS/STP Page No.
Complete crosswalk of state regulations compared to new federal HCBS requirements (scored as alignment, partial alignment, silent, or non-compliant)	Completed	Page 10; Appendix B
<p>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.</p> <p>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.</p>		<p>Page 10; Appendix B</p> <p>Appendix B</p> <p>Appendix B</p>
Determine settings ability to accommodate new HCBS requirements (with scoring outcomes/results)		<p>Page 13 Site Specific Settings Assessments Add to CQS Page 13 Site Specific Settings Assessments or Page 27 Public Engagement Pending</p>
Share site specific settings assessment and validation plan with external stakeholders		Page 13 Remediation Strategies

Pending

[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.]

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[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.]

[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.]

Pending

[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.]

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[The date those settings that are considered institutional or are not willing to remediate will be identified for removal from the HCBS System]

**Add Section Page 14
Provider Removal**

Identify process and settings presented for heightened scrutiny – if necessary.

**Page 14 Heightened
Scrutiny Plan and Process**

**Page 14 Heightened
Scrutiny Plan and Process**

**Page 14 Heightened
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**Page 14 Heightened
Scrutiny Plan and Process**

**Page 15 Relocation Plan
and Process**

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Identify VT plan to relocate consumers – if necessary. Currently in CQS – but may need to be modified as we learn more.

[The date when beneficiaries in approximately 25% of providers have been relocated. Please provide additional details on settings in the description.]

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**Page 15 Relocation Plan
and Process**

[The date when beneficiaries in all providers have been relocated. Please provide additional details on settings in the description.]

Comments

The state has completed the systemic assessments, including review of all rules, regulations, and statutes

[The date when the overall completion of the site-specific assessment, including review of all settings and the validation of assessment results.]

Section	Title	Milestone
I	Systemic Assessment and Remediation	
		1 Completion of systemic assessment
		Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.
		2
		Implementation of new rules and regulations: 50% complete
		Implementation of new rules and regulations: 100% complete
II	Site-specific Assessments (HCBS Survey)	
		1 Completion of site-specific assessment
		Incorporate results of settings analysis into final version of the STP and release for public comment
		2 Submit final STP to CMS
III	Site-specific Remediation ¹	This section includes only those providers where remediation was required.

1 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.

Completion of residential provider
1a remediation: 25%

Completion of residential provider
1b remediation: 50%

Completion of residential provider
1c remediation: 75%

2 Completion of residential provider
1d remediation: 100%
Identify remedial action steps (i. e, corrective action plan) for **nonresidential** settings based on site specific settings assessment and validation activity. Identify plan to validate results/outcomes of site specific settings assessment.

Completion of nonresidential provider
2a remediation: 25%

Completion of nonresidential provider
2b remediation: 50%

Completion of nonresidential provider
2c remediation: 75%

Completion of nonresidential provider
2d remediation: 100%

3 Identification of settings that will not
remain in the HCBS System

IV Heightened Scrutiny²

The first three heightened scrutiny
milestones should be completed prior to
resubmitting the STP to CMS (the fourth HS
milestone)

Identification of settings that overcome
the presumption and will be submitted for
heightened scrutiny and notification to

1 provider

Complete gathering information and
evidence on settings requiring heightened

2 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

3 comment

Submit STP with Heightened Scrutiny

4 information to CMS for review

V Relocation

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Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:14-AM
To: Lane, Sara
Subject: FW: AFC Home Monthly Phone Call Meeting - Thursday February 2, 2017
Attachments: AFC Home Phone Call Agenda_02.02.2017.docx; AFC Home Phone Call - MeetingMinutes_ActionItems_01.05.2017.docx; Immediate Relative.docx; CFC706 _afc_aa_referral_v12016_EDITS_01.04.2017_UPDATED.docx; CFC707 _afc_enrollment_form_v12016_EDITS_01.04.2017_UPDATED.DOCX; CFC-live-in-care-requirements_CFC-live-in-care-agreement_Final Review 11212016.docx; cfc_rights_responsibilities 11212016.doc; 2017 room-and-board-2017-standards-update.pdf

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>

From: Dalley, Jessica
Sent: Wednesday, February 01, 2017 9:25 AM
To: AHS - DAIL ASD LTCCC ; Alysia Chapman (alysiac@howardcenter.org) ; Amber Schaeffler (amber.schaeffler@ncssinc.org) ; Courcelle, Andre ; Bart Mair (bmair@lincolnstreetinc.org) ; Ben Gallagher (beng@howardcenter.org) ; Bonnie Jamieson (bjamieson@ucsvt.org) ; Brenda Donley (brendad@gmssi.org) ; Brent Hewey (bhewey@ccs-vt.org) ; Brown, Paula ; Corey Wilkins (cwilkins@hcrs.org) ; Danielle Boissy (Danielleb@gmssi.org) ; David Wheeler (david@familiesfirstvt.com) ; Dawn Danner (DDanner@ucsvt.org) ; Currier, Debra ; Delaina Norton (delainan@howardcenter.org) ; Heather Goodale (hgoodale@csac-vt.org) ; Fossi, Herman ; Jane Munroe ; Jeanine Chalue (jeaninec@gmssi.org) ; Jennifer Murdoch (jmurdoch@csac-vt.org) ; Jessalyn Gustin (jgustin@uvs-vt.org) ; Dalley, Jessica ; Joan Carman ; Karen Ciechanowicz ; Kenworthy, Kathleen ; Katie Gilcris (kgilcris@hcrs.org) ; Kevin Burke (B1840house@aol.com) ; Kim Daniels (kdaniels@tds.net) ; Kim Lachant ; Kim McCarty (kmccarty@csac-vt.org) ; Laura Martin (lmartin@pridetbi.com) ; Laurie Fay (lfay@uvs-vt.org) ; Linda Ormsbee (lormsbee@comcast.net) ; Lisa Tilton (lisat@gmssi.org) ; Lorraine Gaboriault (lgaboriault@uvs-vt.org) ; Marie Greeno (MGreeno@ccs-vt.org) ; Marilyn Carter (marilync@gmssi.org) ; Corjay, Matthew ; Tierney-Ward, Megan ; Michel Kersten (mkersten@rmhscn.org) ; Michele Corrow (mcorrow@pridetbi.com) ; Nicole Pierce (npierce@hotmail.com) ; Paula Dougherty (pdougherty@csac-vt.org) ; Lane, Sara ; Sharon Tierra (stierra@csac-vt.org) ; Shirley Donohue (sdonohue@howardcenter.org) ; Nelson, Teresa ; Terri Lavelly (t.lavelly@nkhs.net) ; Ashe, William ; Woods, Mary
Subject: AFC Home Monthly Phone Call Meeting - Thursday February 2, 2017

Hello Everyone,

We are looking forward to our *Authorized Agency Choices for Care AFC Home* monthly phone call, scheduled for February 2, 2017 @ 11:00 AM – 12:00 PM.

Call in Number: 1-888-585-9008
Room #: 703101713

Managing the Conference Call:

- *2 Mute/Unmute your own line so other people can't hear you talking**
- *8 Mute/Unmute all participants except moderators - lecture mode**

Please find attached several documents for your reference:

- Agenda
- Meeting Minutes January 2017
- Department of Labor Definition of Family/Immediate Relative
- Room and Board Memo
- CFC 706 Referral Form
- CFC 707 Enrollment/Disenrollment
- Live in Care Requirements /Live in Care Agreement
- CFC/ AFC Participant Rights

The agenda is also included in the body of this e-mail.

We look forward to your participation.

Thank you,

Jessica

AFC Home Phone Call Agenda – January 5, 2017

Introduction of the ASD Adult Family Care team and their roles:

AFC Field Co-ordination (Referrals, Enrollments & Transitions) - *Teresa Nelson*

HCBS Rules – Agency Self-Assessment / Participant Validation - *Andre Courcelle*

Meeting Co-ordination /Notes - *Jessica Dalley*

AFC Process Questions - *Matthew Corjay*

MFP Transition Funds Support / Billing Questions - *Kathleen Kenworthy*

Tier Rate Variances - *Sara Lane*

AFC Quality Reviews - *Andre Courcelle*

Billing Integrity - *Matthew Corjay*

Name	Email Address	Primary Phone Number
Teresa Nelson	Teresa.Nelson@vermont.gov	(802) 595-3706
Andre Courcelle	Andre.Courcelle@vermont.gov	(802) 786-2516

Matthew Corjay	Matthew.Corjay@vermont.gov	(802) 241-0286
Kathleen Kenworthy	Kathleen.Kenworthy@vermont.gov	(802) 241-0298
Sara Lane	Sara.Lane@vermont.gov	(802) 241-0299
Jessica Dalley	Jessica.Dalley@vermont.gov	(802) 241-0289

Agenda Items - February 2, 2017

1. Review Meeting Notes
 - Updates
 - Feedback and Question
2. Live in Care Agreement
 - AFC Policy and alignment regarding protective monitoring requests and process
 - Termination of Agreement - differences between traditional tenant/landlord
3. CFC 707 Enrollment Disenrollment
 - Discussing alternative
4. CFC 706 Referral
 - Process review
 - Information and Instructions for providers
5. Transportation to access community
 - How to address issue
6. Hospitalizations
 - Home up Keep
7. Pre-Transition Payments
 - Ongoing Work
 - Developing alternatives
8. Update on HCBS Provider self-assessment - Andre Courcelle
9. Agenda Topics for next meeting - March 2, 2017

Jessica R. Dalley

Administrative Assistant

Money Follows the Person Project

Department of Disabilities, Aging & Independent Living

Adult Services Division

HC 2 South, 280 State Drive, Waterbury, VT 05671-2070

Main Line: (802) 241-0289

Fax: (802) 241-0385

Jessica.Dalley@vermont.gov

AFC Home Phone Call Agenda February 2, 2017

Introduction of the ASD Adult Family Care team and their roles:

AFC Field Co-ordination (Referrals, Enrollments & Transitions)	<i>Teresa Nelson</i>
HCBS Rules – Agency Self-Assessment / Participant Validation	<i>Andre Courcelle</i>
Meeting Co-ordination / Notes	<i>Jessica Dalley</i>
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Tier Rate Variances	<i>Sara Lane</i>
AFC Quality Reviews	<i>Andre Courcelle</i>
Billing Integrity	<i>Matthew Corjay</i>

Name	Email Address	Primary Phone Number
Teresa Nelson	Teresa.Nelson@vermont.gov	(802) 595-3706
Andre Courcelle	Andre.Courcelle@vermont.gov	(802) 786-2516
Matthew Corjay	Matthew.Corjay@vermont.gov	(802) 241-0286
Kathleen Kenworthy	Kathleen.Kenworthy@vermont.gov	(802) 241-0298
Sara Lane	Sara.Lane@vermont.gov	(802) 241-0299
Jessica Dalley	Jessica.Dalley@vermont.gov	(802) 241-0289

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Immediate Relative

An individual with any of the following relationships to the employee:

1. Spouse, and parents thereof;
2. Sons and daughters, and spouses thereof;
3. Parents, and spouses thereof;
4. Brothers and sisters, and spouses thereof;
5. Grandparents and grandchildren, and spouses thereof;
6. Domestic partner and parents thereof, including domestic partners of any individual in 1 through 5 of this definition; and
7. Any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Participant Information

Full Name: _____
Last First M.I.

Address: _____

City State ZIP Code

Home Phone: _____

Birth Date: _____

Enrollment

I, _____, agree to enroll with the
 _____, as my agency of choice to work on my behalf to find
 a shared living arrangement for me on this date: _____.

Participant Signature: _____

Authorized Agency Signature: _____

Disenrollment

I, _____, wish to terminate my agreement with the above
 listed Agency effective on this date: _____.

Participant Signature: _____

Authorized Agency Signature: _____

Reason (s) for terminating the agreement (optional): _____

Referral made to another Authorized Agency:

☐ No ☐ Yes **Agency Name:** _____

Authorized Agency sends a copy of this form to the Local LTCCC Nurse

Pre-Transition Process

Pre-Transition Services Include:

- a. Interviewing and enrolling the CFC participant with the AA
- b. Developing a person-centered plan
- c. Advertising for AFC home providers
- d. Arranging for and assuring completed AFC home inspections according to CFC standards
- e. Orienting/training the approved AFC home provider
- f. Creating a contract with the approved AFC home provider
- g. Managing other required AFC documentation
- h. Attending discharge planning meetings

Once the AA has verified that an individual is clinically and financially eligible for Choices for Care and has chosen AFC, the AA may begin providing AFC pre-transition services for reimbursement using the following protocol:

1. Participants shall receive AFC pre-transition services from one AA at a time.
2. To receive pre-transition services, a participant must enroll with the chosen AA.
3. The AA Enrollment/Disenrollment form must be signed by the AA and the participant.
4. The participant can voluntarily terminate the agreement at any time. The AA and participant must sign the Enrollment/Disenrollment form with date of termination.
5. The AA enrollment form must be sent to the LTCCC Nurse.
6. Pre-transition services will end when the person moves into an approved AFC home or within 60 non-consecutive days of the signature date on the AA's enrollment form, whichever is sooner.
7. Any transition delays must be communicated between the AA and LTCCC Nurse.
8. AA's submit for reimbursement using the Adult Family Care revenue code 086 at \$35 per day for up to 60 non-consecutive days from the signature date on the Enrollment/Disenrollment form.
9. Billing can only occur for the actual date the pre-transition services were provided. If the time exceeds 60 non-consecutive days, then the work continues without daily reimbursement.
10. The individual has the option to sign the Disenrollment portion of the form and work with another AA. If the individual dis-enrolls, the Enrollment/Disenrollment form must be sent to the LTCCC Nurse with the disenrollment portion of the form filled out.
11. On the date the participant moves into the approved AFC home, the AA may bill the full approved tier rate that appears on the authorized CFC Service Plan, following the applicable CFC standards.
12. AA's shall maintain documentation of all pre-transition activities which are to be made available to the State upon request.

Authorized Agency sends a copy of this form to the Local LTCCC Nurse

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:11 AM
To: Lane, Sara
Subject: FW: Follow up question on CFC HHA/AAAs
Attachments: VT CFC Brief Action Plan COI HCBS.PDF

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>

From: Skaflestad, Shawn
Sent: Monday, May 08, 2017 12:19 PM
To: Tierney-Ward, Megan ; Lane, Sara
Subject: FW: Follow up question on CFC HHA/AAAs

Just following up on my email below. Any thoughts re: how we should respond to CMS?

Shawn

From: Skaflestad, Shawn
Sent: Friday, May 05, 2017 10:40 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Lane, Sara <Sara.Lane@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>; Gustafson, Cory <Cory.Gustafson@vermont.gov>; Hickman, Selina <Selina.Hickman@vermont.gov>; Clark, Sarah <Sarah.Clark@vermont.gov>
Subject: FW: Follow up question on CFC HHA/AAAs

Hi Megan and Sara,

In Selina's absence, I am looking to respond to the CMS follow up question highlighted in the message below. This inquiry is related to our request for a "geographic exception" from the new HCBS rules (specifically the conflict free case management requirement) taken from the *CFC Action Plan* that was submitted to CMS last summer (attached). Item 1a on page 6 of the attachment reads as follows:

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.*

As a reminder, the new rules indicate that HCBS service providers must not provide case management for a person they serve, except when the state is granted a geographic exception. I am not sure how geographic area was defined in this document – but could you provide some suggested text to clarify the assertion that there is only one willing and able provider (HHA or AAA) to perform case management and provide HCBS services in various regions of the state.

Thank you,

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



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



- 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 primary 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		Ma	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								

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.										

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:10 AM
To: Lane, Sara
Subject: FW: Follow up question on CFC HHA/AAAs

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>

From: Skaflestad, Shawn
Sent: Monday, May 08, 2017 1:49 PM
To: Tierney-Ward, Megan ; Lane, Sara ; George, Camille
Subject: RE: Follow up question on CFC HHA/AAAs

I have not spoken with CMS directly about this issue – but they appear to be interested in entertaining our request for an exception. My understanding from their email below is that they need a bit more information re: the scope of our request (e.g., is it for certain counties, certain AHS districts, state-wide, or some other specific geographic region) – as well as a bit more evidence (i.e., is there truly only one able and willing provider for case management and to deliver services).

Shawn

From: Tierney-Ward, Megan
Sent: Monday, May 08, 2017 1:08 PM
To: Skaflestad, Shawn <Shawn.Skaflestad@vermont.gov>; Lane, Sara <Sara.Lane@vermont.gov>; Suzanne Santarcangelo <ssantarcangelo@phpg.com>; George, Camille <Camille.George@vermont.gov>
Subject: RE: Follow up question on CFC HHA/AAAs

We may want to consult with Suzanne Santarcangelo on this one. She was key to helping draft the letter to CMS requesting their technical assistance on the case management conflict of interest issue and she may already have something drafted that would work. I'm including Camille as well since she was also involved in this discussion.

If CMS is asking for this, does it mean they are considering an exception? (Previously they acted as though they would not consider it.)

Megan

From: Skaflestad, Shawn
Sent: Monday, May 08, 2017 12:19 PM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Lane, Sara <Sara.Lane@vermont.gov>
Subject: FW: Follow up question on CFC HHA/AAAs

Just following up on my email below. Any thoughts re: how we should respond to CMS?

Shawn

From: Skaflestad, Shawn
Sent: Friday, May 05, 2017 10:40 AM
To: Tierney-Ward, Megan <megan.tierney-ward@vermont.gov>; Lane, Sara <Sara.Lane@vermont.gov>
Cc: Hutt, Monica <Monica.Hutt@vermont.gov>; Gustafson, Cory <Cory.Gustafson@vermont.gov>; Hickman, Selina <Selina.Hickman@vermont.gov>; Clark, Sarah <Sarah.Clark@vermont.gov>
Subject: FW: Follow up question on CFC HHA/AAAs

Hi Megan and Sara,

In Selina's absence, I am looking to respond to the CMS follow up question highlighted in the message below. This inquiry is related to our request for a "geographic exception" from the new HCBS rules (specifically the conflict free case management requirement) taken from the *CFC Action Plan* that was submitted to CMS last summer (attached). Item 1a on page 6 of the attachment reads as follows:

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.*

As a reminder, the new rules indicate that HCBS service providers must not provide case management for a person they serve, except when the state is granted a geographic exception. I am not sure how geographic area was defined in this document – but could you provide some suggested text to clarify the assertion that there is only one willing and able provider (HHA or AAA) to perform case management and provide HCBS services in various regions of the state.

Thank you,

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: Lane, Sara
Sent: Tuesday, July 17, 2018 10:10 AM
To: Lane, Sara
Subject: FW: HCBS Provider Doc
Attachments: Vermont HCBS Plan Provider Questions.docx

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>

From: Gerstenberger, Roy
Sent: Monday, May 15, 2017 3:52 PM
To: Skaflestad, Shawn ; O'Neill, Chris ; Lane, Sara ; Courcelle, Andre ; McFadden, Clare
Subject: HCBS Provider Doc

Here is an updated version. Comments are welcome.

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
Find us on  <https://www.facebook.com/vtddsd/>



Vermont's Plan to Comply with New Federal
Home and Community-Based Services Requirements
Provider Questions and Answers

This Question and Answer document provides an overview of the requirements from the final regulations for

Home and Community-Based Services (HCBS), published by the federal Centers for Medicare and Medicaid Services (CMS). The final regulations require HCBS Waiver settings to comply with them by March 17, 2019. The new regulations are located at 42 CFR 441.301(c)(4), (5) and 441.710(a)(1), (2). Vermont's plan for complying with these regulations is available at the following web address:

<http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy>

1. What are the new federal HCBS rules, and what is the Statewide Transition Plan?

The new federal HCBS rules apply to Medicaid HCBS Waiver settings. The rules are designed to enhance the quality of home and community-based services, provide additional protections to HCBS program participants, and ensure that individuals receiving services through HCBS programs have full access to the benefits of community living. (The rules state requirements for HCBS settings, and they grant states and settings until March 17, 2022, to comply.) Sites that do not comply by that date would be barred by federal law from participating in an HCBS Medicaid waiver program.

In response to these new federal rules, Vermont developed a Comprehensive Quality Strategy Plan, available at the above link, to show how Vermont will help providers meet the new federal HCBS rules. The state kicked off the plan by trying to get a better understanding of where the sites stand in relation to the new rules through a self-assessment survey. Vermont will evaluate and categorize each site based on the survey results, as explained in Question 3 below. After categorization, some sites will receive an on-site validation visit and a remediation plan, if needed, to reach full compliance. This is explained further in Questions 4 and Question 5. Generally, sites can expect this on-site process to be similar to their existing regular reviews. After the on-site visit, many sites may need to make some changes in order to reach full

compliance. The State plans to continue working with providers during the transition period to help them reach compliance by March 17, 2022. The new federal rules will become one of the things the State looks for in its routine monitoring checks.

2. To whom do the rules apply?

This rule applies to all agencies, residential and non-residential, that provide Medicaid services under any of

3. I have heard that the State has divided its providers into categories. What does the category classification mean to me?

To determine whether waiver providers already comply with the federal rule or whether they need to make changes, Vermont asked its waiver providers to complete a self-assessment survey. These surveys helped divide all providers into three different categories:

1. Settings that fully align with the federal requirements;
2. Settings that do not comply with the federal requirements but may comply with modifications; and
3. Settings that are presumably not home and community-based (i.e., are presumed to be institutional), but for which the State may provide justification/evidence through the federal heightened scrutiny process to show that the settings do not have the characteristics of an institution and do have the qualities of home and community-based settings.

The categorization itself will not lead to any action or decision on whether a setting complies with the federal rule; it will help establish the method the State will use to determine whether a setting meets the federal rule.

Category 1 or 2 settings will be asked to be sure they comply by the March 17, 2022 deadline. Those settings are likely to have to make minor changes (or no changes at all for Category 1) to show that they are compliant. Those sites may be asked to send the State a letter or other documentation so that the State knows they have made any changes needed for compliance, as explained in Question 7.

Category 3 settings presumed to be institutional. As with Category 2, settings that fall into Category 3 will not be shut down automatically. Instead, Category 3 settings must be approved through the federal heightened scrutiny process (described in Question 8) in order to continue to participate in Illinois Medicaid's HCBS programs.

4. Will I receive an on-site visit as part of the assessment process?

Federal CMS requires the State to “validate” the results of its provider surveys by having on-site visits.

The State expects to begin this process by publishing a list of the sites it has placed in Category 4 (to the extent it can do so without violating privacy interests) to get public comment on how those settings were categorized. The State’s on-site reviewers will use any public input to help create the results for on-site visits.

For Category 1 and 2 settings, federal CMS requires the State to do on-site visits to a “statistically valid sample” of settings. State reviewers will make their work, interviews, and inspections for this plan fit into the work they normally do to monitor settings.

All settings that have been categorized as Category 3 or Category 4 can expect an on-site visit. This process will be similar to existing visits, and will be conducted by the normal oversight agency the setting already works with (see Question 2). This process is further explained in Question 5.

This survey validation process will happen only one time. Once the surveys have been validated, settings’ compliance with the new federal rule will be monitored on an ongoing basis as part of the State’s normal review process.

5. What can I expect in an on-site visit?

Each setting that will receive an on-site visit, can expect this visit to be conducted by its normal oversight agency. The State will make this on-site visit align as much as possible with existing monitoring. The State intends most of the HCBS on-site visits to take place at the same time as other, already planned on-site monitoring visits. The on-site visits will include interaction with individual clients, record reviews, meetings with key setting staff, and reviews of individual service plans, all by the agencies and personnel most qualified to conduct the reviews for the setting in question. All on-site reviews will be conducted using a checklist the State developed based on published CMS guidance

6. What types of actions should I take to prepare for an on-site visit?

Sites should prepare for the on-site visit in the same way they prepare for their existing regular reviews. In order to minimize the burden on providers, the State will combine the HCBS Plan on-site visit with existing State visits.

7. What types of changes will I be required to make to comply with the federal HCBS rules?

For agencies whose assessment survey and validation show only small areas of non-compliance, the setting will be asked to (1) submit documentation such as a letter describing the changes that have been made to achieve full compliance along with specific dates; and (2) demonstrate full compliance with both the claims in the letter and with the HCBS requirements.

For agencies with more substantial non-compliance with the rule, the State will require the setting to submit a corrective action plan for achieving full compliance before the effective date of the federal rule, March 17, 2022. The state will notify providers within 90-days of the site review if these letters of correction are needed.

8. What are the minimum expectations of the corrective action plan?

The corrective action plan should include short term steps to update written policies, contract wording, staff training and changes in recruitment and home provider selection strategies to address the protections of the new rules. These include but are not limited to:

- The individual has privacy in their home including lockable doors, choice of roommates and freedom to furnish or decorate;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The person's home is physically accessible.

and any relevant alterations to ensure that a person is supported in a setting that is:

- Integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

9. How will the state expect compliance with the need for residency agreements?

The following must be included in a Residency Agreement:

- Reasons for which an individual may be asked to move out
- Minimum of 30-day notification for exit notices

- Notification of the individual's appeal rights when they are asked to move out
- Conditions when a provider may give less than a 30-day notice
- Signature of the individual (or the individual's legal representative)

If a person lives in a home that is owned by someone else and is receiving services funded through HCBS Medicaid, then they must have this protection from an agency with authority to provide the protections. Therefore this agreement can be between a person and their designated agency or specialized service agency.

10. What if there is a need to have conditions in place for someone's safety that may compromise the protections outlined in the new HCBS rules?

There may be instances where appropriate limitations have been determined and justified in the person-centered plan consistent with § 42 CFR section 442.301(c)(4) and 441.530 (a)(1)(vi)(F) that outlines the process for modifying any of the conditions required for the individual's assessed need. The following must be evident in the plan:

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

11. What is the "Heightened Scrutiny" process?

The new federal rule says that certain types of settings, such as

- Farmstead intentional communities,
- Settings that are designed specifically for people with disabilities, or for people with a certain type of disability.

These must be presumed to be institutional. That is, the federal rule requires Vermont to assume these sites do not comply. Those sites will be placed in Category 3, described in Question 3. However, the federal rule provides a process that lets the State argue that a Category 3 site should be able to stay on as a Medicaid waiver provider. This process is called the “heightened scrutiny process.”

Under that process, the State may present evidence to federal CMS that a site that has been presumed to be institutional is home- or community-based. The federal government has the final authority to decide whether a provider is a community or institutional setting. The State makes the initial determination on whether to challenge the presumption and seek federal heightened scrutiny review.

To make this determination, the State will form a Personal Outcome Assessment Team. Members of the team will include state Quality Service Review (QSR) personnel, representatives from the agency operating the site, employees from community agencies and self-advocates. Team members will receive training and credentialing from the Council on Quality & Leadership in the use of Personal Outcome Measures. Interviews will be conducted with the people who experience the setting. The findings of the assessment team will be evaluated by the Department of Disability, Aging & Community Living (DAIL) who will make the final determination on whether to apply to CMS for consideration of continued funding with HCBS Medicaid.

The State understands that settings exist in the system that currently exhibit features that make them appear to be institutional under the federal rules. Because the State recognizes that there are advocates who hold the position that such settings should play a role in the system, it will work with the Personal Outcomes Assessment Team as well as advocates who hold different positions about whether such settings should be a component of the system to determine if evidence should be presented to the federal government that they are well-integrated programs.

12. What is the timeline for this project?

The State has already taken several steps towards complying with the new federal rule, including development of a Comprehensive Quality Strategy plan and the survey process of HCBS settings. The State expects to complete all of the on-site visits as well as initial Heightened Scrutiny recommendations for this process by the end of Fiscal Year 2018. Any applications to CMS for heightened scrutiny will be available for public notice and comment prior to submission to CMS. Additionally, the State will modify review documents, DD Act rules, and provider agreements. While the State will be working towards several important deadlines, everything must be completed by March 17, 2022.

13. Where can I find more information?

Final HCBS Regulation: <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>

HCBS Training by CMS: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/longterm-services-and-supports/home-and-community-based-services/hcbs-training.html>

Exploratory Questions to Assist States in Assessment of Residential Settings -
<https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-re-settings-characteristics.pdf>

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:13 AM
To: Lane, Sara
Subject: FW: HCBS Provider Self-Assessment

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>

From: Tierney-Ward, Megan
Sent: Wednesday, April 05, 2017 12:00 PM
To: Lane, Sara ; Courcelle, Andre ; Forkas, Colleen ; Smith-Dieng, Angela ; Corjay, Matthew
Subject: HCBS Provider Self-Assessment

Below is a copy of the email communication for the HCBS provider self-assessment that was sent to our HCBS providers on Monday. AHS is using Survey Gizmo and Shawn Skaflestad is the person at AHS who generated the communication. If anyone asks, the link to the survey is located under my name in the email communication. It is easy to miss.

Also, just a heads up, if Shawn gets any incorrect emails or contact information generated from Survey Gizmo, he will reach out to ASD for corrections. If this happens, I may need your help getting him the correct information.

Thanks!

Megan

From: Survey Research [<mailto:invites@mailers.surveygizmo.com>]
Sent: Monday, April 03, 2017 4:29 PM
To: rlec@sover.net
Subject: Shawn.Skaflestad needs your feedback!

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 valuable time and feedback.

Sincerely,

Megan Tierney-Ward, Director

Adult Services Division

Vermont Department of Disabilities, Aging & Independent Living

<http://s-749105-i.sgizmo.com/s3/i-kJpMKXsje7kHe2dA9-1786261/?sguid=kJpMKXsje7kHe2dA9>

This message was sent by Shawn.Skaflestad, 280 State Drive Center Building, Waterbury, Vermont 05671.
To unsubscribe, click below: [Unsubscribe](#)

No virus found in this message.

Checked by AVG - www.avg.com

Version: 2016.0.8012 / Virus Database: 4769/14233 - Release Date: 04/03/17



(<https://hcbadvocacy.org/>)

COALITION

Information for advocates about the new home and
community-based services rules
(<https://hcbadvocacy.org/>)

Learn About the New Rule

Use this page to find official resources and information from the federal government regarding the rule.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services have provided fact sheets, webinar slides, informational bulletins, and toolkits on [Medicaid.gov/hcbs](http://www.medicaid.gov/hcbs) (<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>). These resources are copied below. Visit [Medicaid.gov/hcbs](http://www.medicaid.gov/hcbs) (<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>) for the most up-to-date information from CMS on the HCBS settings rule.

Final Regulation Announcement

The final Home and Community-Based Services regulations set forth new requirements for several Medicaid authorities under which states may provide home and community-based long-term services and supports. The regulations enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

- **Final Regulation:** 1915(i) State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) HCBS Waivers – CMS-2249-F/CMS-2296-F (<https://www.federalregister.gov/articles/2014/01/16/2014-00487/state-plan-home-and-community-based-services-5-year-period-for-waivers-provider-payment-reassignment>)
 - **Informational Bulletin** – Final regulations for HCBS provided under Medicaid's 1915(c), 1915(i), and 1915(k) authorities (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-10-14.pdf>)
 - **Press Release** – Final regulations for HCBS provided under Medicaid's 1915(c), 1915(i) and 1915(k) authorities (<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-10-2.html>)
 - **Fact Sheets Regarding Final Regulation CMS-2249-F/CMS-2296-F**

- Overview of Regulation
(<http://www.aucd.org/docs/policy/HCBS/references/final-rule-fact-sheet-%20self%20directed.pdf>)
- 1915(c): Changes to HCBS Waiver Program
(<https://www.medicaid.gov/medicaid/hcbs/downloads/1915c-fact-sheet.pdf>)
- 1915(i): Key Provisions for HCBS State Plan Option
(http://www.aucd.org/docs/policy/HCBS/references/1915i-fact-sheet-Key_Provisions.pdf)
- Summary of Key Provisions of the HCBS Settings Final Rule
(<http://www.aucd.org/docs/policy/HCBS/references/hcbs-setting-fact-sheet.pdf>)
- HCBS Final Rule Webinar Presentation Download
(<https://www.medicaid.gov/medicaid/hcbs/downloads/final-rule-slides-01292014.pdf>)
- Final Rule: Questions and Answers
(<http://www.aucd.org/docs/policy/HCBS/references/final-q-and-a-CFC.pdf>)
- Key Provisions of the Final HCBS Rule
(<http://www.aucd.org/docs/policy/HCBS/references/final-rule-fact-sheet-%20self%20directed.pdf>) (January 10, 2014)

Settings Requirements Compliance Toolkit

CMCS is pleased to share with State Medicaid Agencies, Operating Agencies, and other stakeholders a Home and Community-Based Settings Toolkit to assist states develop Home and Community-Based 1915(c) waiver and 1915(i) SPA amendment or renewal application(s) to comply with new requirements in the recently published Home and Community Based Services' (HCBS) regulations. The toolkit includes:

- A summary of the regulatory requirements
(<http://www.aucd.org/docs/policy/HCBS/references/requirements-for-home-and-community-settings.pdf>) of fully compliant HCB settings and those settings that are excluded.
- Schematic drawings of the heightened scrutiny process
(<http://www.aucd.org/docs/policy/HCBS/references/heightened-scrutiny%20flow%20chart.pdf>) as a part of the regular waiver life cycle and the HCBS 1915(c) compliance flowchart (<http://www.aucd.org/docs/policy/HCBS/references/hcbs-1915c-waiver-compliance-flowchart.pdf>). Heightened Scrutiny Questions and Answer
(<http://www.aucd.org/docs/policy/HCBS/references/home-and-community-based-setting-requirements-Heightened%20Scrutiny.pdf>) (June 26, 2015)
- Additional technical guidance on regulatory language regarding settings that isolate
(<http://www.aucd.org/docs/policy/HCBS/references/FAQ%20settings-that-isolate.pdf>).
- Guidance on the implementation of the Community First Choice State Plan Option
(<http://www.aucd.org/docs/policy/HCBS/references/FAQ%20CFC.pdf>) (December 30, 2016)
- Exploratory questions that may assist states in the assessment of:

- Residential Settings
(<http://www.aucd.org/docs/policy/HCBS/references/exploratory-questions-re-settings-characteristics.pdf>)
- Non-Residential Settings
(<http://www.aucd.org/docs/policy/HCBS/references/exploratory-questions-non-residential.pdf>)
- Questions and Answers Regarding Home and Community-Based Settings
(<http://www.aucd.org/docs/policy/HCBS/references/q-and-a-hcb-settings-Public%20Notice%20and%20Comment.pdf>)
- Statewide Transition Plan Toolkit
(<http://www.aucd.org/docs/policy/HCBS/references/statewide-transition-plan-toolkit.pdf>)
for Alignment with HCB Settings Regulation Requirements Suggestions for alternative approaches and considerations for states as they prepare and submit Statewide Transition Plans for the new federal requirements for residential and non-residential home and community-based settings. The regulatory requirements can be found at 42 CFR 441.301(c)(4)(5) and 441.710(a)(1)(2).
- HCBS Basic Element Review Tool for Statewide Transition Plans and HCBS Content Review Tool for Statewide Transition Plans (<http://www.kdads.ks.gov/docs/default-source/CSP/HCBS/hcbs-settings-final-rule/settings-final-rule-cms-guidance/2014-09-05-basic-elements-review-hcbs-statewide-transition-plan.pdf?sfvrsn=2>)
- Frequently Asked Questions Regarding the Heightened Scrutiny Review Process and Other Home and Community-Based Settings Information
(<http://www.aucd.org/docs/policy/HCBS/references/home-and-community-based-setting-requirements-Heightened%20Scrutiny.pdf>)
- Frequently Asked Questions on Planned Construction and Person-Centered Planning Requirements (<http://www.aucd.org/docs/policy/HCBS/references/faq-planned-construction.pdf>)

HHS-Wide Guidance on Person-Centered Planning and Self Direction

On June 6, the Secretary of Health and Human Services issued guidance regarding person-centered planning and self-direction. The guidance is applicable across HHS offices, including in HCBS.

- Read the Administration for Community Living blog post
(http://www.acl.gov/NewsRoom/blog/2014/2014_07_09.aspx): *Person-Centered Planning and Self-Direction* regarding the HSS Guidance on Implementing Section 2402(a) of the Affordable Care Act.

Additional Resources


- Informational Bulletin on 1915(c) Employment and Employment Related Services (<http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf>)
- Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers (<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf>)
- State Medicaid Director's Letter- August 2010 – Improving Access to Home and Community-Based Services (<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10015.pdf>)
- List of 1915(c) Waiver Renewals Expected Through April 2015 (<https://hcbsadvocacy.org/1915c-waiver-renewals-expected-through-april-2015/>)


Office of Disability Employment Programs

Archived Webinar: Implications of HCBS Final Rule on Non Residential Settings (<https://www.youtube.com/watch?v=h70-DmMNoEg>)

The U.S. Department of Labor's Office of Disability Employment Policy, in collaboration with the Disability & Elderly Public Health Group within the Centers for Medicare and Medicaid Services, presented this webinar for state policy-makers and disability policy stakeholders to discuss recent Federal policy guidance issued by CMS. The webinars included a brief presentation by CMS followed by a highly interactive dialogue to address questions on the impact of these Federal policy developments on state systems-change efforts related to improving integrated employment and community-based engagement of citizens with significant disabilities.

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Have Resources to Share?

Send them to: hcbsadvocacy@gmail.com (<mailto:hcbsadvocacy@gmail.com>)

Open Comment Periods

See state page for instructions on how to submit your comments

- Connecticut due September 3, 2018 (<https://portal.ct.gov/DSS/Health-And-Home-Care/Long-Term-Care/Community-Options/Documents>)
- West Virginia, due July 30, 2018 (<https://dhhr.wv.gov/bms/Public%20Notices/Pages/The-Bureau-for-Medical-Services-is-pleased-to-announce-the-third-iteration-of-the-West-Virginia-State-Wide-Transition-Plan.aspx>)
- Rhode Island, Due August 9, 2018
([https://www.aucd.org/docs/policy/HCBS/HCBS%206.7.18%20\(002\).pdf](https://www.aucd.org/docs/policy/HCBS/HCBS%206.7.18%20(002).pdf))

CMS' Additional Feedback for Final Approval

1. New Hampshire, April 4 (<http://www.aucd.org/docs/policy/HCBS/NH%20STP%20Final%20Approval%20Feedback%20for%20Publication.pdf>)
2. Alaska, April 4 (<http://www.aucd.org/docs/policy/HCBS/AK%20STP%20Final%20Approval%20Feedback%20for%20Publication.pdf>)
3. Louisiana, April 4 (<http://www.aucd.org/docs/policy/HCBS/LA%20STP%20Final%20Approval%20Feedback%20for%20Publication.pdf>)
4. North Carolina, April 4 (<http://www.aucd.org/docs/policy/HCBS/NC%20STP%20Final%20Approval%20Feedback%20for%20Publication.pdf>)
5. Hawaii, March 13 (<https://www.medicaid.gov/medicaid/hcbs/downloads/hi/hi-initial-approval-addendum.pdf>)

STP Approvals from CMS

Final Approvals (in order by approval date)

1. Wyoming, June 29, 2018 (<https://www.aucd.org/docs/policy/HCBS/WY%20Final%20Approval.pdf>)
2. Washington, October 24, 2017 (<http://www.aucd.org/docs/policy/HCBS/WA%20STP%20Final%20Approval%20Letter.pdf>)
3. DC, October 6, 2017 (<http://www.aucd.org/docs/policy/HCBS/DC%20Initial%20and%20Final%20Approval.pdf>)
4. Oklahoma, August 10, 2017 (<http://www.aucd.org/docs/policy/HCBS/OK%20Final%20Approval%20Letter.pdf>)
5. Kentucky, June 13, 2017 (<http://www.aucd.org/docs/policy/HCBS/KY%20STP%20Final%20Approval%20Letter.pdf>)
6. Arkansas, June 2, 2017 (<http://www.aucd.org/docs/policy/HCBS/AR%20STP%20Final%20Approval%20Letter.pdf>)
7. Tennessee, April 13, 2016
(<http://www.aucd.org/docs/policy/HCBS/references/TNProposedAmendedStatewideTransitionPlanCV.pdf>)

Initial Approvals (in order by approval date)

1. California, February 23, 2018 (<https://www.aucd.org/docs/policy/HCBS/CA%20Initial%20Approval.pdf>)
2. Vermont, December 5, 2017 (<http://www.aucd.org/docs/policy/HCBS/VT%20Initial%20Approval.pdf>)
3. Georgia, October 25, 2017 (<http://www.aucd.org/docs/policy/HCBS/GA%20STP%20Initial%20Approval%20Letter.pdf>)
4. Arizona, September 6, 2017 (<http://www.aucd.org/docs/policy/HCBS/AZ%20Initial%20Approval%20Letter.pdf>)
5. North Carolina, September 6, 2017 (<http://www.aucd.org/docs/policy/HCBS/NC%20STP%20initial%20approval%20letter.pdf>)
6. Michigan, August 10, 2017 (<http://www.aucd.org/docs/policy/HCBS/MI%20Initial%20Approval%20letter.pdf>)
7. Maryland, August 2, 2017 (<http://www.aucd.org/docs/policy/HCBS/MD%20Initial%20Approval%20Letter.pdf>)
8. Wisconsin, July 14, 2017 (<http://www.aucd.org/docs/policy/HCBS/WI%20Initial%20Approval.pdf>)
9. New Hampshire, July 3, 2017 (<http://www.aucd.org/docs/policy/HCBS/NH%20Initial%20Approval%20Letter.pdf>)
10. Minnesota, June 2, 2017 (<http://www.aucd.org/docs/policy/HCBS/MN%20STP%20Initial%20Approval%20Letter.pdf>)
11. South Dakota, June 2, 2017 (<http://www.aucd.org/docs/policy/HCBS/SD%20STP%20Initial%20Approval%20Letter.pdf>)
12. Mississippi, May 25, 2017 (<http://www.aucd.org/docs/policy/HCBS/MS%20Initial%20Approval%20Letter.pdf>)
13. Wyoming, May 10, 2017 ([http://www.aucd.org/docs/policy/HCBS/WY%20Initial%20Approval%20Letter%20\(002\).pdf](http://www.aucd.org/docs/policy/HCBS/WY%20Initial%20Approval%20Letter%20(002).pdf))
14. Utah, April 5, 2017 (<http://www.aucd.org/docs/policy/HCBS/UT%20STP%20Initial%20Approval.pdf>)
15. Nebraska, March 31, 2017 (<http://www.aucd.org/docs/policy/HCBS/NE%20STP%20Initial%20Approval.pdf>)
16. Missouri, March 29, 2017 (<http://www.aucd.org/docs/policy/HCBS/MO%20Initial%20Approval.pdf>)
17. Louisiana, March 3, 2017 (<http://www.aucd.org/docs/policy/HCBS/LA%20Initial%20Approval.pdf>)
18. Alabama, February 21, 2017 (<http://www.aucd.org/docs/policy/HCBS/AL%20Initial%20Approval.pdf>)
19. New Mexico, January 13, 2017 (<http://www.aucd.org/docs/policy/HCBS/NM%20Initial%20Approval%20Letter.pdf>)
20. Hawaii, January 13, 2017 (<http://www.aucd.org/docs/policy/HCBS/HI%20Initial%20Approval%20Letter.pdf>)
21. Rhode Island, January 5, 2017 (<http://www.aucd.org/docs/policy/HCBS/RI%20Initial%20Approval%20Attachment%20I%20CMIA%201-5-2017.pdf>)

22. Alaska, December 28, 2016
(http://www.aucd.org/docs/policy/HCBS/Alaska_STP_Initial_Approval.pdf)
23. Montana, December 23, 2016
(http://www.aucd.org/docs/policy/HCBS/MT_STP_Initial_Approval_Letter_12-23-16.pdf)
24. Virginia, December 9, 2016 (<http://www.aucd.org/docs/policy/HCBS/VA%20STP%20Initial%20Approval%20Letter%2012-09-16.pdf>)
25. Indiana, November 8, 2016 (<http://www.aucd.org/docs/policy/HCBS/IN%20STP%20Initial%20Approval%20Letter%2011-08-16.pdf>)
26. Washington State, November 3, 2016
(http://www.aucd.org/docs/policy/HCBS/Washington_STP_Initial_Approval_11-4-16.pdf)
27. South Carolina, November 3, 2016
(http://www.aucd.org/docs/policy/HCBS/South_Carolina_STP_Initial_Approval_11-4-16.pdf)
28. Oregon, November 2, 2016 (<http://www.aucd.org/docs/policy/HCBS/OR%20STP%20Initial%20Approval%2011-2-16.pdf>)
29. North Dakota, November 1, 2016 (<http://www.aucd.org/docs/policy/HCBS/ND%20STP%20Initial%20Approval%20Letter%2011-1-2016.pdf>)
30. West Virginia, October 26, 2016 (<http://www.aucd.org/docs/policy/HCBS/WV%20Initial%20Approval%20Letter%20Revised%20on%2031-10-2016.pdf>)
31. Connecticut, October 21, 2016 (<http://www.aucd.org/docs/policy/HCBS/CT%20STP%20Initial%20Approval%20Letter%20Revised%20on%2011-1-16.pdf>)
32. Idaho, September 23, 2016
(<http://www.aucd.org/docs/policy/HCBS/references/id-initial-approval.pdf>)
33. Pennsylvania, August 30, 2016
(<http://www.aucd.org/docs/policy/HCBS/references/pa-initial-approval.pdf>)
34. Iowa, August 9, 2016 (<http://www.aucd.org/docs/policy/HCBS/references/ia-initial-approval-cmia.pdf>)
35. Delaware, July 14, 2016 (<http://www.aucd.org/docs/policy/HCBS/references/de-initial-approval.pdf>)
36. Ohio, June 2, 2016 (<http://www.aucd.org/docs/policy/HCBS/references/oh-intl-appvl.pdf>)

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WE TEAMED UP WITH EVENTBRITE ([HTTP://EVENTBRITE.COM/L/WORDPRESS?REF=WPFOOTER](http://eventbrite.com/L/wordpress?ref=wpfooter))

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

- [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 \(/sites/asd/files/documents/TBI Reference Table HCBS Regs.pdf\)](/sites/asd/files/documents/TBI%20Reference%20Table%20HCBS%20Regs.pdf)
- [TBI Program Work Plan \(/sites/asd/files/documents/TBI HCBS Work Plan.pdf\)](/sites/asd/files/documents/TBI%20HCBS%20Work%20Plan.pdf)

TAGS:

[Human Rights \(/tags/human-rights\)](/tags/human-rights/) |

[Long Term Services and Supports \(/tags/long-term-services-and-supports\)](/tags/long-term-services-and-supports/) |

[Medicaid \(/tags/medicaid\)](/tags/medicaid/) | [Standards \(/tags/standards\)](/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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[DAIL Department Scorecard](#)

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:13 AM
To: Lane, Sara
Subject: FW: HCBS Provider Self-Assessment

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>

From: Tierney-Ward, Megan
Sent: Wednesday, April 05, 2017 12:00 PM
To: Lane, Sara ; Courcelle, Andre ; Forkas, Colleen ; Smith-Dieng, Angela ; Corjay, Matthew
Subject: HCBS Provider Self-Assessment

Below is a copy of the email communication for the HCBS provider self-assessment that was sent to our HCBS providers on Monday. AHS is using Survey Gizmo and Shawn Skaflestad is the person at AHS who generated the communication. If anyone asks, the link to the survey is located under my name in the email communication. It is easy to miss.

Also, just a heads up, if Shawn gets any incorrect emails or contact information generated from Survey Gizmo, he will reach out to ASD for corrections. If this happens, I may need your help getting him the correct information.

Thanks!

Megan

From: Survey Research [<mailto:invites@mailers.surveygizmo.com>]
Sent: Monday, April 03, 2017 4:29 PM
To: rlec@sover.net
Subject: Shawn.Skaflestad needs your feedback!

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 valuable time and feedback.

Sincerely,

Megan Tierney-Ward, Director

Adult Services Division

Vermont Department of Disabilities, Aging & Independent Living

<http://s-749105-i.sgizmo.com/s3/i-kJpMKXsje7kHe2dA9-1786261/?sguid=kJpMKXsje7kHe2dA9>

This message was sent by Shawn Skaflestad, 280 State Drive Center Building, Waterbury, Vermont 05671
To unsubscribe, click below: [Unsubscribe](#)

No virus found in this message.

Checked by AVG - www.avg.com

Version: 2016.0.8012 / Virus Database: 4769/14233 - Release Date: 04/03/17

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:10 AM
To: Lane, Sara
Subject: FW: HCBS Rules: Person Centered Planning and Settings Information
Attachments: CMS-Person-Centered Planning.pdf

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>

From: Lane, Sara
Sent: Monday, May 08, 2017 2:24 PM
To: Senghas, Stuart
Subject: FW: HCBS Rules: Person Centered Planning and Settings Information

This is info I sent to our LTC Team (LTCCC's & TC's). You may find it helpful too?

Sara Lane, BSN, RN
Aging and Disabilities Program Manager
DAIL- Adult Services Division
HC 2 South, 280 State Drive
Waterbury, VT 05671
Phone: (802) 241.0299
Fax: (802) 241.0385
Email: sara.lane@vermont.gov

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



From: Lane, Sara
Sent: Friday, April 28, 2017 2:58 PM
To: AHS - DAIL ASD LTCCC <AHS.DAILASDLTCCC@vermont.gov>
Cc: Brown, Paula <paula.brown@vermont.gov>; Woods, Mary <Mary.Woods@vermont.gov>; Coutu, Deb <Deb.Coutu@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>; Corjay, Matthew <Matthew.Corjay@vermont.gov>
Subject: HCBS Rules: Person Centered Planning and Settings Information

At our April LTC Team meeting Andre provided an update on the work to implement the Home and Community Based Services (HCBS) Rules specific to person centered planning and settings.

As a recap, work has been done with various provider groups: Adult Day, Case Managers, Authorized Agencies for AFC, TBI to work together to integrate the HCBS rule language into the respective provider standards or policies/procedures. (DS has also done this with their network) These rules do not officially go into effect until 2019. The next step is for the various provider groups to complete a self assessment to determine where they need to strengthen compliance with the HCBS rules. When the self assessments are completed, there will be a validation of the assessments by way of interviewing the recipients/participants of the service providers. The compliance and practice of the HCBS rules will be ensured through quality reviews for each provider group.

Keep in mind that the HCBS rules do not apply to our Residential Care and Assisted Living Providers as they are not considered an HCBS setting by CMS. CMS identifies them as a PNMI- Private Non-Medical Institution. With this said philosophically we support the settings and person centered planning rules, so when we are able to re-open the regulations for these provider types, we can work with the providers to incorporate some of the rules into the regulations.

Some of you asked about resources for person centered planning, so you can start integrating/sharing elements of this practice with your waiver teams.

Below are links to information/resources for both person centered planning and settings rules. I also attached a document, as well. Happy reading and let me know if any questions come up for you.

<https://acl.gov/Programs/CPE/OPAD/docs/Person-Centered-Planning-and-HCBS.pdf>

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-10-2.html>

<https://www.medicaid.gov/medicaid/hcbs/guidance/index.html>

-Sara

Sara Lane, BSN, RN
Aging and Disabilities Program Manager
DAIL-Adult Services Division
HC 2 280 State Dr.
Waterbury, VT 05671-2070
Phone: 802.241-0299
Fax: 802.241.0385
Email: sara.lane@vermont.gov

SECTION VIII. Choices for Care (CFC) Participant's Rights & Responsibilities

A. Choices for Care Participant's Rights

1. Every participant shall be treated with consideration, respect with full recognition of the participant's dignity, individuality and privacy.
2. Each participant shall be allowed to associate, communicate and meet privately with persons of the participant's own choice.
3. A participant may voice a complaint without interference, coercion or reprisal.
4. The participant's right to privacy extends to all records and personal information. Personal information about a participant shall not be discussed with anyone not directly involved in the participant's care. Release of any record, excerpts from or information contained in such records shall be subject to the participant's written approval, except as requested by representatives of the Authorized Agency or DAIL to carry out its responsibilities or as otherwise provided by law.
5. The participant has the right to review their person-centered plan, care plan, medical or financial records upon request.
6. Participants shall be free from mental, verbal or physical abuse, neglect, and exploitation.
7. Participants have the right to formulate advance directives as provided by state law and to have these wishes honored.
8. Participants have the right to choose their own doctor and other health care professionals.
9. Participants have the right to be informed about eligibility for other services and the circumstances under which these services may be available to the participant.
10. These participants' rights shall not limit, modify, abridge or reduce in any way any rights that a participant otherwise enjoys as a human being and citizen
11. Receive services without regard to race, religion, color, creed, gender, national origin, sexual orientation, marital status, or disability;

12. Be treated as an individual with consideration, dignity and respect including but not limited to person, residence and possessions;
13. Have services provided that support your health and welfare;
14. Assume reasonable risks and have the opportunity to learn from these experiences;
15. Be fully informed of the process for requesting a new Care Manager and/or requesting a Fair Hearing any time while you are participating in the TBI Program;

B. Choices for Care (CFC) Program Participant's Responsibilities

As a CFC program participant, you are responsible to:

1. Provide to the best of your knowledge, complete and accurate medical history including all prescribed and over the counter medications you are taking and understand the risk(s) associated with your decisions about care.
2. Maintain your home in a manner which enables you to safely live in the community.
3. Ask questions when you do not understand your services.
4. Not participate in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the CFC program may be jeopardized.
5. Report any significant changes in your medical condition, circumstances, informal supports and formal supports to your Care Team.
6. Provide accurate information related to your coverage under Medicaid, including any notices from the Department for Children & Families Economic Services Division regarding your Medicaid, Medicare or other medically-related insurance programs to your service providers.
7. Notify all providers as soon as possible if the scheduled services visit needs to be rescheduled or changed.
8. Treat your Service Providers with consideration, dignity and respect.

AFC Home Phone Call Meeting Minutes/Action Items

January 5, 2017

Introduction of the ASD Adult Family Care team and their roles:

AFC Field Co-ordination (Referrals, Enrollments & Transitions)	<i>Teresa Nelson</i>
HCBS Rules - Agency Self-Assessment / Participant Validation	<i>Andre Courcelle</i>
Meeting Co-ordination / Notes	<i>Jessica Dalley</i>
AFC Process Questions	<i>Matthew Corjay</i>
MFP Transition Funds Support / Billing Questions	<i>Kathleen Kenworthy</i>
Tier Rate Variances	<i>Sara Lane</i>
AFC Quality Reviews	<i>Andre Courcelle</i>
Billing Integrity	<i>Matthew Corjay</i>

Name	Email Address	Primary Phone Number
Teresa Nelson	Teresa.Nelson@vermont.gov	(802) 595-3706
Andre Courcelle	Andre.Courcelle@vermont.gov	(802) 786-2516
Matthew Corjay	Matthew.Corjay@vermont.gov	(802) 241-0286
Kathleen Kenworthy	Kathleen.Kenworthy@vermont.gov	(802) 241-0298
Sara Lane	Sara.Lane@vermont.gov	(802) 241-0299
Jessica Dalley	Jessica.Dalley@vermont.gov	(802) 241-0289

Review of Meeting Minutes - December 1, 2016

Review of AFC Referral Form - CFC706

- Copies of the referral form to be sent to Teresa Nelson
- Informed consent language
- Suggestions/Comments on referral process
- Referral source discussion - who is the referral source? Suggested that the referral source be responsible for referral follow-up until an agency is chosen or participant is enrolled.

Action Item:

1. *Informed consent language has been sent to the legal team*
2. *Development of instructions and dispersing information*

Review of AFC Enrollment/Disenrollment Form – CFC707

1. Concern with process termination and tracking of de-enrollments
 - Suggested practice is that enrollment or de-enrollment is completed or terminated between the agency and the participant electronically or via postal mail.

Action Item:

1. *Final draft of AFC Enrollment/Disenrollment Form – CFC707 will be released upon final review.*

Review of Live in Care Requirements

1. Relative definition
2. Room and Board
 - Monthly “Reasonable Payment” definition – what are the Medicaid guidelines? Should this be clarified in the requirements?
 - Suggested best practice is that negotiation between the Home Provider and Participant is in the best interest of the Participant

Action Item:

1. *Provide definition for relative*
2. *Provide definition for reasonable payment and request to add language to be included in requirements*

Review of Live in Care Agreement

1. Twenty-four-hour protective supervision
 - Suggested to add “Human Rights Commission” language into Live in Care Agreement as Human Rights Commission has expectations for monitoring devices regarding human rights restrictions. Questions may be directed to Andre regarding this process.
2. Termination of Live in Care Agreement
 - Tenant/Landlord Rights – should there be language or reference to appeal rights?
 - Agreement between Home Provider and Participant differ from standard Landlord/Tenant rights and are laid out in the agreement for live in care. AFC Participant rights are outlined in the Choices for Care manual.

Action Item:

1. *Further clarification of tenant rights*

Payment

1. Hospitalizations for more than thirty days
 - Home provider does not get paid beyond thirty-day hospitalization – Can participants utilize home upkeep?

Action Item:

1. *Verification needed regarding use of home upkeep beyond 30 days*

Transportation

1. Transportation difficulties for participant to have access to the community beyond medical appointments

Action Item:

1. *Brainstorm suggestions regarding alternative transportation – ie. Patient Share reduction to access transportation, variances on transportation costs.*

Quality Overview – Andre Courcelle

1. Time allotted for Quality segment of AFC Meeting going forward
2. Quality Reviews for AFC
 - Reviews based on standard for AFC program
 - Record review of required documentation
 - Interviews with Participant, Home Provider or direct staff working with Participant
 - Participant satisfaction – are services working, is there room for improvement?

Action Item:

1. *Ongoing Quality Reviews will be conducted by Andre' and Quality team member*
2. *As standards evolve, Quality's goal is to develop higher standards and partner with agencies as a means for quality improvement for all Participants.*

Open Meeting Topics/Action Items

Penalty on services due to spenddown

Question regarding Home Provider payments

Agency self-assessments

CFC 706 additional comments

Returned mail/Notice of Decision issues

Date: _____

Referral Source/ Agency:

Referral Source Name: _____ Phone: _____

List all Authorized Agencies Receiving Referral:

(Please send a copy to Teresa Nelson at Teresa.Nelson@vermont.gov)

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Participant Demographic Info

Name: _____ Date of Birth: _____

Mailing Address: _____

Participant's current location: _____

Participant's desired location: _____

Reason for desired location: ☐ Family/Relative ☐ Friends ☐ Other _____

Date of Admission: _____

Name of participant's contact/guardian/legal rep (if any): _____

Phone: _____

Relationship to individual: ☐ Guardian ☐ Legal Representative ☐ Representative Payee ☐ Family/Relative

Assessed Tier: _____

*By signing this Informed Consent, you are allowing agencies to discuss information regarding your individual case.
(Language to be discussed with legal)*

Name: _____

Date: _____

Signature: _____

Participant Medical Care Needs

Check all that apply:

Two Person Assist in 1 or more ADLs:

☐ Toileting ☐ Transferring ☐ Bathing ☐ Dressing ☐ Mobility

Medical Treatments:

☐ Oxygen Therapy ☐ Chemotherapy ☐ Radiation Therapy ☐ Gastric Tube Feeding ☐ Suctioning

☐ Parenteral Feedings ☐ Dialysis ☐ Transfusions ☐ Wound Care ☐ Medication
Injections

☐ Other: _____

Traumatic Brain Injury: ☐ Yes ☐ No

Dementia/Alzheimer's Diagnosis: ☐ Yes ☐ No

Behaviors:

☐ Wandering ☐ Verbal Aggression ☐ Physical Aggression ☐ Socially Inappropriate ☐ Resistant to Care

☐ Other: _____

Mental Health Diagnosis/treatment plan:

☐ Psychologist ☐ Psychiatrist ☐ CRT ☐ Other: _____

Behavior Plan: ☐ Yes ☐ No

Medications: ☐ Independent ☐ Needs Assist

High Risk Factors: ☐ Alcohol dependency ☐ Drug dependency ☐ Smoking

Environmental allergies: ☐ Pets ☐ Wood stove smoke ☐ Flowers ☐ Candles

☐ Other: _____

Food Allergies: ☐ Yes ☐ No Please List: _____

Accessibility Needs**Wheel Chair accessible:** ☐ Yes ☐ No☐ Manual Wheel Chair ☐ Electric Wheel Chair ☐ Scooter ☐ Other: _____**1st Floor/Ground Level living quarters needed (unable to do stairs):** ☐ Yes ☐ No**Stair glide needed:** ☐ Yes ☐ No**Able to share a bathroom:** ☐ Yes ☐ No**Participant Social History****Self-Neglect:** ☐ Yes ☐ No**Adult Protective Services:** ☐ Past ☐ Current:
_____**History of Incarceration:** ☐ Yes ☐ NoIf yes, please explain:
_____**Violent Behavior:** ☐ Yes ☐ NoIf yes, please explain:
_____**Participant Preferences****Pets in home:** ☐ Cats ☐ Dogs ☐ Rodents (hamsters, guinea pigs) ☐ Rabbits☐ Other: _____**Smoking:** ☐ Yes ☐ No**Food/meals:** ☐ Independent ☐ Needs Assist**Children in home:** ☐ Yes ☐ No ☐ No Preference**Other non-related individuals in home:** ☐ Yes ☐ No ☐ No Preference**Participant desired location (Town or City):** _____☐ Rural ☐ Urban ☐ City ☐ No Preference**Reason for desired location:** _____**Religious Affiliation:** ☐ Yes: _____ ☐ No

Other Important Information

Please see Information attached (or documented below):

AFC Referral Process:

1. Who fills out the Referral Form?
 - Social Worker at Nursing Home or Hospital
 - Friend or Family
 - Case Manager
2. Obtain Current AFC Referral Form
3. Complete Referral Form with the most current and accurate information available
4. Have Participant sign Informed Consent allowing information to be shared between agencies
5. Send Referral Form to any agencies from the list chosen by the Participant and Care Team. Ensure copy of Referral Form is sent to Teresa Nelson.
6. Within two weeks of receipt of referral, the agency shall contact the referral source regardless if there is interest in pursuing placement of the participant.
7. The referral source is responsible for contacting all agencies that received the referral if the Participant enrolls with another agency.

Authorized Agency	Address	Contact
Champlain Community Services	512 Troy Ave, Colchester, VT 05446	Karen Cienchanowicz (802) 655-0511 X 120 Kciechanowicz@ccs-vt.org
Choice Brain Injury Support Services	5 School Avenue, Montpelier, VT 05601	Nicole Pierce (802) 622-8122 npierce@hotmail.com
Counseling Services of Addison County, Inc.	109 Catamount Park, Middlebury, VT 05753	Paula Dougherty (802) 388-4021 pdougherty@csac-vt.org
Families First	26 Elliot Terrace, Brattleboro, VT 05301	David Wheeler (802) 275-4919 david@familiesfirstvt.com
Green Mountain Support Services (Formerly Sterling Area Services)	109 Professional Dr., Morrisville, VT 05661	Marilyn Carter (802) 888-7602 marilync@sterlingarea.org
Health Care and Rehab Services (HCRS)	390 River Street, Springfield, VT 05156	Corey Wilkins (802) 463-3294 X 2781 cwilkins@hcrs.org
Head Injury Stroke Independence Project	1409 US 7 Wallingford, VT AKA Lenny Burke Farm	Kevin Burke (802) 446-2302 B1840house@aol.com
Howard Center	322 St. Paul Street, Burlington, VT 05401	Delaina Norton (802) 488-6543 delainan@howardcenter.org
Lincoln Street Incorporated	374 River Rd., Springfield, VT 05156	Bart Mair (802) 886-1833 X 113 bmair@lincolnstreetinc.org
Northeast Kingdom Human Services	P.O. Box 724, Newport, VT 05855	Terri Lavelly (802) 748-6350 x 1111 t.lavelly@nkhs.net
Northwestern Counseling and Support Services	107 Fisher Pond Rd., St. Albans, VT 05478	Amber Schaeffler (802) 393-6641 amber.schaeffler@ncssinc.org
PRIDE	P.O. Box 969, Barre, VT 05641	Kim Daniels (802) 479-5801 kdaniels@tds.net
Rutland Mental Health Services	78 South Main St., Rutland, VT 05702	Michel Kirsten (802) 786-7305 mkersten@rmhscn.org
United Counseling Services	10 Ledge Hill Dr., Bennington, VT 05201	Bonnie Jamieson (802) 442-5491 X 294 bjamieson@ucsvt.org
Upper Valley Services	P.O. Box 4409, White River Junction, VT 05001	Jessalyn Gustin (802) 222-9235 jgustin@uvs-vt.org

Date: _____

Referral Source/ Agency: _____

Referral Source Name: _____ Phone: _____

List all Authorized Agencies Receiving Referral:

(Please send a copy to Teresa Nelson at Teresa.Nelson@vermont.gov)

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Agency: _____ Contact: _____

Participant Demographic Info

Name: _____ Date of Birth: _____

Mailing Address: _____

Participant's current location: _____

Participant's desired location: _____

Reason for desired location: ☐ Family/Relative ☐ Friends ☐ Other _____

Date of Admission: _____

Name of participant's contact/guardian/legal rep (if any): _____

Phone: _____

Relationship to individual: ☐ Guardian ☐ Legal Representative ☐ Representative Payee ☐ Family/Relative

Assessed Tier: _____

*By signing this Informed Consent, you are allowing agencies to discuss information regarding your individual case.
(Language to be discussed with legal)*

Name: _____

Date: _____

Signature: _____

Participant Medical Care Needs

Check all that apply:

Two Person Assist in 1 or more ADLs:

☐ Toileting ☐ Transferring ☐ Bathing ☐ Dressing ☐ Mobility

Medical Treatments:

☐ Oxygen Therapy ☐ Chemotherapy ☐ Radiation Therapy ☐ Gastric Tube Feeding ☐ Suctioning

☐ Parenteral Feedings ☐ Dialysis ☐ Transfusions ☐ Wound Care ☐ Medication
Injections

☐ Other: _____

Traumatic Brain Injury: ☐ Yes ☐ No

Dementia/Alzheimer's Diagnosis: ☐ Yes ☐ No

Behaviors:

☐ Wandering ☐ Verbal Aggression ☐ Physical Aggression ☐ Socially Inappropriate ☐ Resistant to Care

☐ Other: _____

Mental Health Diagnosis/treatment plan:

☐ Psychologist ☐ Psychiatrist ☐ CRT ☐ Other: _____

Behavior Plan: ☐ Yes ☐ No

Medications: ☐ Independent ☐ Needs Assist

High Risk Factors: ☐ Alcohol dependency ☐ Drug dependency ☐ Smoking

Environmental allergies: ☐ Pets ☐ Wood stove smoke ☐ Flowers ☐ Candles

☐ Other: _____

Food Allergies: ☐ Yes ☐ No Please List: _____

Accessibility NeedsWheel Chair accessible: ☐ Yes ☐ No☐ Manual Wheel Chair ☐ Electric Wheel Chair ☐ Scooter ☐ Other: _____1st Floor/Ground Level living quarters needed (unable to do stairs): ☐ Yes ☐ NoStair glide needed: ☐ Yes ☐ NoAble to share a bathroom: ☐ Yes ☐ No**Participant Social History**Self-Neglect: ☐ Yes ☐ NoAdult Protective Services: ☐ Past ☐ Current:
_____History of Incarceration: ☐ Yes ☐ NoIf yes, please explain:
_____Violent Behavior: ☐ Yes ☐ NoIf yes, please explain:
_____**Participant Preferences**Pets in home: ☐ Cats ☐ Dogs ☐ Rodents (hamsters, guinea pigs) ☐ Rabbits☐ Other: _____Smoking: ☐ Yes ☐ NoFood/meals: ☐ Independent ☐ Needs AssistChildren in home: ☐ Yes ☐ No ☐ No PreferenceOther non-related individuals in home: ☐ Yes ☐ No ☐ No Preference

Participant desired location (Town or City): _____

☐ Rural ☐ Urban ☐ City ☐ No Preference

Reason for desired location: _____

Religious Affiliation: ☐ Yes: _____ ☐ No

Other Important Information

Please see Information attached (or documented below):

AFC Referral Process:

1. Who fills out the Referral Form?
 - Social Worker at Nursing Home or Hospital
 - Friend or Family
 - Case Manager
2. Obtain Current AFC Referral Form
3. Complete Referral Form with the most current and accurate information available
4. Have Participant sign Informed Consent allowing information to be shared between agencies
5. Send Referral Form to any agencies from the list chosen by the Participant and Care Team. Ensure copy of Referral Form is sent to Teresa Nelson.
6. Within two weeks of receipt of referral, the agency shall contact the referral source regardless if there is interest in pursuing placement of the participant.
7. The referral source is responsible for contacting all agencies that received the referral if the Participant enrolls with another agency.

Authorized Agency	Address	Contact
Champlain Community Services	512 Troy Ave, Colchester, VT 05446	Karen Cierchanowicz (802) 655-0511 X 120 Kciechanowicz@ccs-vt.org
Choice Brain Injury Support Services	5 School Avenue, Montpelier, VT 05601	Nicole Pierce (802) 622-8122 npierce@hotmail.com
Counseling Services of Addison County, Inc.	109 Catamount Park, Middlebury, VT 05753	Paula Dougherty (802) 388-4021 pdougherty@csac-vt.org
Families First	26 Elliot Terrace, Brattleboro, VT 05301	David Wheeler (802) 275-4919 david@familiesfirstvt.com
Green Mountain Support Services (Formerly Sterling Area Services)	109 Professional Dr., Morrisville, VT 05661	Marilyn Carter (802) 888-7602 marilync@sterlingarea.org
Health Care and Rehab Services (HCRS)	390 River Street, Springfield, VT 05156	Corey Wilkins (802) 463-3294 X 2781 cwilkins@hcrs.org
Head Injury Stroke Independence Project	1409 US 7 Wallingford, VT AKA Lenny Burke Farm	Kevin Burke (802) 446-2302 B1840house@aol.com
Howard Center	322 St. Paul Street, Burlington, VT 05401	Delaina Norton (802) 488-6543 delainan@howardcenter.org
Lincoln Street Incorporated	374 River Rd., Springfield, VT 05156	Bart Mair (802) 886-1833 X 113 bmair@lincolnstreetinc.org
Northeast Kingdom Human Services	P.O. Box 724, Newport, VT 05855	Terri Lavery (802) 748-6350 x 1111 t.lavery@nkhs.net
Northwestern Counseling and Support Services	107 Fisher Pond Rd., St. Albans, VT 05478	Amber Schaeffler (802) 393-6641 amber.schaeffler@ncssinc.org
PRIDE	P.O. Box 969, Barre, VT 05641	Kim Daniels (802) 479-5801 kdaniels@tds.net
Rutland Mental Health Services	78 South Main St., Rutland, VT 05702	Michel Kirsten (802) 786-7305 mkersten@rmhscn.org
United Counseling Services	10 Ledge Hill Dr., Bennington, VT 05201	Bonnie Jamieson (802) 442-5491 X 294 bjamieson@ucsvt.org
Upper Valley Services	P.O. Box 4409, White River Junction, VT 05001	Jessalyn Gustin (802) 222-9235 jgustin@uvs-vt.org

Choices for Care Live-in Care Requirements

Live-in Care Agreement for Services

It is the policy of the Department of Disabilities, Aging and Independent Living (DAIL), Adult Services Division (ASD) to support individuals to reside in the setting of their choice as indicated in a person-centered plan. Person-centered planning shall happen in a timely manner and will occur at a time and location that is convenient to the Participant. One housing option is shared living/live-in care, which for this purpose, is an arrangement in which an individual resides in the private home of a caregiver (home provider) who is not related to them through either blood or marriage. The home is unlicensed and the home provider may not care for more than two unrelated individuals in the home at one time.

All live-in care arrangements must have a written agreement with the individual who is participating in the Vermont Choices for Care program. The agreement must contain the following required elements and terms. A copy of this form must be kept in the participant record at the Authorized Agency (AA).

I. Agreements must identify the following:

1. The name of the caregiver/homeowner,
2. The name of the Resident,
3. The location of the home,
4. The date that the living arrangement will begin (or began),
5. The monthly "reasonable" payment for room & board which includes the cost of:
 - a. Shelter,
 - b. Access to food, and
 - c. Basic utilities (electricity, heat, water, sewer, trash removal, and access to basic telephone services)
6. A description of the household arrangements to include:
 - a. bedroom arrangements, private or shared, (remove private or shared)
 - b. bathroom arrangements, private or shared,
 - c. kitchen arrangements, private or shared or not available,
 - d. living room arrangements, private or shared or not available, and
 - e. other common space arrangements, private or shared or not available
 - f. lockable doors
 - g. the right to furnish/decorate the Participant's living unit
7. List all other services and the costs associated,
8. Termination requirements by each party,
9. List of other conditions of the agreement, including a house rules and conditions of the living arrangement,
10. Signatures and dates of signature of the Resident (or legal representative when applicable),
11. Signature of the caregiver/homeowner provider,
12. Signature of the Surrogate Employer (if applicable).
13. The home provider agrees to deliver the services identified in the person-centered plan and care plan. The home provider agrees to give the participant receiving services free choice of attending social activities (based on local availability).
14. The home provider agrees to accept Choices for Care reimbursement as full and final payment for delivery of the authorized services.
15. The home provider agrees to participate in assessments and on-going monitoring with the service coordinator or staff of the Vermont Agency of Human Services.

II. Agreements must include the following terms:

Resident/Participant shall be free to come and go from the home and exercise the right to control his/her own schedule and activities to the extent they are able independently or with the help of others. In addition, they have the right to privacy, to include lockable doors and shall be free to receive calls and visits/visitors at any time (scheduled and unscheduled) from friends, family and case managers within the specified house rules as listed under "*Other Conditions of this Agreement*".

1. The caregiver/homeowner agrees to deliver the services according to the person- centered plan and care plan. The home provider agrees to give the participant receiving services free choice of attending social activities (based on local availability).
2. The home provider agrees to accept Choices for Care reimbursement as full and final payment for delivery of the authorized services.
3. The home provider agrees to participate in assessments and on-going monitoring with the AFC service coordinator or staff of the Vermont Agency of Human Services.

The Department of Disabilities, Aging and Independent Living (DAIL), Adult Services Division (ASD), has attached a model of this agreement for your convenience. The agreement must be completed upon move in with the caregiver/homeowner and renewed only as conditions of the living arrangement change.

Any Modifications to the setting requirements must be:

1. Supported by specific assessed need
2. Justified in the person-centered service plan
3. Documented in the person-centered service plan

Modifications must be reviewed anytime the person-centered plan is revised.

Agreement for Live-in Care Including Vermont Choices for Care Services

This is an agreement between _____
(Home Provider Name), and _____ (Participant Name),
to enter into a living arrangement where room, board, and Choices for Care, Long-Term Care services
and supports will be provided at (address of residence) _____

This living arrangement will begin (or began) on (date) _____.

Room & Board:

Participant (or legal representative) agrees to pay the caregiver/homeowner \$ _____ each
month for housing, access to food, and basic utilities.

Household Arrangements: (check all that apply)

Bedroom:	<input type="checkbox"/> private	<input type="checkbox"/> shared	
Bathroom:	<input type="checkbox"/> private	<input type="checkbox"/> shared	
Kitchen:	<input type="checkbox"/> private	<input type="checkbox"/> shared	<input type="checkbox"/> not available
Living Room:	<input type="checkbox"/> private	<input type="checkbox"/> shared	<input type="checkbox"/> not available
Other Common Space:	<input type="checkbox"/> private	<input type="checkbox"/> shared	<input type="checkbox"/> not available
Furnishing:	<input type="checkbox"/> private	<input type="checkbox"/> shared	<input type="checkbox"/> not available

Other Services:

In addition to the above room & board, the resident (or legal representative) agrees to pay the
caregiver/homeowner \$ _____ for the following goods and services that are not
otherwise included in room and board as follows: (check all that apply)

- ☐ 24-hour protective presence (supervision) ☐
- transportation
- ☐ cable/satellite television
- ☐ toiletries/personal care items
- ☐ Other _____
- ☐ Other _____

Resident Rights and Privileges:

- a. Resident/Participant shall be free to come and go from the home and exercise the right to control his/her own schedule and activities to the extent they are able to independently or with the help of others. The Participant shall have the right to furnish/decorate his/her own living unit. In addition, the Participant has the right to privacy and shall be free to receive calls and visits/visitors anytime (scheduled and unscheduled) from friends, family and case managers within the specified house rules as listed under "Other Conditions of this Agreement".

VT Choices for Care Program:

The home provider agrees to deliver the services identified in the person-centered plan, care plan and the Choices for Care service authorization. The home provider agrees to give the individual free choice of attending social activities (based on local availability).

The home provider agrees to accept Choices for Care reimbursement as full and final payment for delivery of authorized Choices for Care services.

The caregiver/homeowner agrees to participate in assessments and on-going monitoring with the AA service coordinator or staff of the Department of Disabilities, Aging and Independent Living.

Termination of Agreement:

The parties will give each other at least _____ days notice prior to ending this arrangement with the exception of emergency situations.

Other Conditions of this Agreement: *(attach additional pages is necessary)*

Signatures:

We agree to the conditions of this agreement:

Resident (or legal representative) signature

Date

Surrogate Employer signature (if applicable)

Date

Caregiver/homeowner signature

Date



State of Vermont

Department of Disabilities, Aging and Independent Living
 Adult Services Division & Developmental Disabilities Services Division
 HC 2 South, 280 State Drive
 Waterbury, VT 05671-2070
 Phone: 802-241-0294 & 802-241-0304
 Fax: 802-241-0385
 www.dail.vermont.gov

Agency of Human Services

MEMO

To: Licensed Level III and Assisted Living Providers
 Developmental Services Providers,
 TBI Services Providers
 Adult Family Care Authorized Agencies

From: Megan Tierney-Ward, ASD Director
 Roy Gerstenberger, DDS Director

Date: January 3, 2017

Re: Room & Board Memo – 2017 Standards Update

The Department of Disabilities, Aging and Independent Living (DAIL) has been notified that effective January 1, 2017, SSI benefits were increased by \$2 per month to reflect an increase in the cost of living (COLA). This memo is to communicate the new room & board and minimum personal spending amounts allowed under the DAIL room & board standards.

With the 2017 SSI increase, the room & board standard will increase by \$1 and the personal needs allowance will also increase by \$1. Please refer to the accompanying table for exact amounts based on the setting.

As a reminder, providers must ensure that individuals retain the required minimum personal spending amount listed in the table. *However, providers may choose to charge a person less for room and board payment so the resident may retain a greater personal needs spending allowance.*

Providers must also give residents proper notice of any change in room & board charges according to applicable licensing regulations and program standards.

Please contact your applicable state program representative with questions.

C: ASD Staff
 DDS Staff
 DLP Staff





Developmental Services

Description	Total SSI 2017	Room & Board	Minimum Personal Spending
Unlicensed Residential Care Home (also called <i>Board and Care Home</i> or <i>Developmental Home</i> or <i>Shared Living</i>)	833.69	708.69	125.00
Licensed Residential Care Home <i>Level III without ACCS</i>	1002.13	877.13	125.00
Licensed Residential Care Home <i>Level IV/TCR</i>	958.94	833.94	125.00
Independent Living	787.04	N/A	N/A

Section 6.2 of the Developmental Services Regulations specifies that the above designation shall be full and complete payment for room and board for people receiving residential services funded through the home and community-based waiver. The same section governs individuals with private means to pay room and board.

TBI Services

Description	Total SSI 2017	Room & Board	Minimum Personal Spending
Unlicensed Residential Care Home (also called <i>Board and Care Home</i> or <i>Developmental Home</i> or <i>Shared Living</i>)	833.69	724.69	109.00
Licensed Residential Care Home <i>Level III without ACCS</i>	1002.13	893.13	109.00
Licensed Residential Care Home <i>Level IV/TCR</i>	958.94	849.94	109.00
Independent Living	787.04	N/A	N/A

Choices for Care – Adult Family Care

Description	Total SSI 2017	Room & Board	Minimum Personal Spending
Adult Family Care Home	833.69	708.69	125.00

Assistive Community Care Services (which includes CFC Enhanced Residential Care)

Description	Total SSI 2017	*Room & Board	Minimum Personal Spending
Licensed Level III Residential Care Home and Assisted Living Residences with ACCS <i>*Residents living in a private room with income above SSI may be charged room & board up to 85% of their net income after Medicaid standard deductions and medical deductions.</i>	783.38	*709.38	74.00

<u>Medicaid Protected Income Limit (PIL)</u>	<u>2016</u>	<u>2017</u>
<i>Outside</i> Chittenden County:	\$1008	\$1025
<i>Inside</i> Chittenden County:	\$1083	\$1108

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:11 AM
To: Lane, Sara
Subject: FW: AFC Monthly Meeting Agenda - Thursday May 4, 2017
Attachments: AFC Home Phone Call Agenda_05.04.2017.docx

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>

From: Dalley, Jessica
Sent: Wednesday, May 03, 2017 4:06 PM
To: AHS - DAIL ASD LTCCC ; Alysia Chapman (alysiac@howardcenter.org) ; Amber Schaeffler (amber.schaeffler@ncssinc.org) ; Courcelle, Andre ; Bart Mair (bmair@lincolnstreetinc.org) ; Ben Gallagher (beng@howardcenter.org) ; Bonnie Jamieson (bjamieson@ucsvt.org) ; Brenda Donley (brendad@gmssi.org) ; Brent Hewey (bhewey@ccs-vt.org) ; Brown, Paula ; Corey Wilkins (cwilkins@hcrs.org) ; Coutu, Deb ; Danielle Boissy (danielleb@gmssi.org) ; David Wheeler (david@familiesfirstvt.com) ; Dawn Danner (DDanner@ucsvt.org) ; Currier, Debra ; Delaina Norton (delainan@howardcenter.org) ; Heather Goodale (hgoodale@csac-vt.org) ; Fossi, Herman ; Jane Munroe ; Jeanine Chalue (jeaninec@gmssi.org) ; Jennifer Murdoch (jmurdoch@csac-vt.org) ; Jessalyn Gustin (jgustin@uvs-vt.org) ; Dalley, Jessica ; Joan Carman ; Karen Ciechanowicz ; Kenworthy, Kathleen ; Katie Gilcris (kgilcris@hcrs.org) ; Kevin Burke (B1840house@aol.com) ; Kim Lachant ; Kim McCarty (kmccarty@csac-vt.org) ; Laura Martin (lmartin@pridetbi.com) ; Laurie Fay (lfay@uvs-vt.org) ; Linda Ormsbee (lormsbee@comcast.net) ; Lisa Tilton (lisat@gmssi.org) ; Lorraine Gaboriault (lgaboriault@uvs-vt.org) ; Marie Greeno (MGreeno@ccs-vt.org) ; Marilyn Carter (marilync@gmssi.org) ; Corjay, Matthew ; Tierney-Ward, Megan ; Michel Kersten (mkersten@rmhscn.org) ; Michele Corrow (mcorrow@pridetbi.com) ; Michelle Dindo ; Nancy Welcome ; Nicole Pierce (npierce@hotmail.com) ; Paula Dougherty (pdougherty@csac-vt.org) ; Lane, Sara ; Sharon Tierra (stierra@csac-vt.org) ; Shirley Donohue (sdonohue@howardcenter.org) ; Nelson, Teresa ; Terri Lavelly (t.lavelly@nkhs.net) ; Ashe, William ; Woods, Mary
Subject: AFC Monthly Meeting Agenda - Thursday May 4, 2017

Good Afternoon,

Please find attached the agenda for tomorrow's meeting from 11:00 AM – 12:00 PM.

Please use the call in information below:

Conference Phone Number: 1-888-585-9008

Conference Room Number: 999416806

We look forward to your attendance!

*Thank you,
Jessica*

*Jessica R. Dalley
Administrative Assistant
Money Follows the Person Project
Department of Disabilities, Aging & Independent Living
Adult Services Division
HC 2 South, 280 State Drive, Waterbury, VT 05671-2070
Main Line: (802) 241-0289
Fax: (802) 241-0385
Jessica.Dalley@vermont.gov*

AFC Home Phone Call Agenda May 4, 2017

ASD Adult Family Care team and their roles:

AFC Field Co-ordination (Referrals, Enrollments & Transitions)
 HCBS Rules - Agency Self-Assessment / Participant Validation
 Meeting Co-ordination / Notes
 AFC Process Questions
 MFP Transition Funds Support / Billing Questions
 Tier Rate Variances
 AFC Quality Reviews
 Billing Integrity

Teresa Nelson
Andre Courcelle
Jessica Dalley
Matthew Corjay
Kathleen Kenworthy
Sara Lane
Andre Courcelle
Matthew Corjay

Name	Email Address	Primary Phone Number
Teresa Nelson	Teresa.Nelson@vermont.gov	(802) 595-3706
Andre Courcelle	Andre.Courcelle@vermont.gov	(802) 786-2516
Matthew Corjay	Matthew.Corjay@vermont.gov	(802) 241-0286
Kathleen Kenworthy	Kathleen.Kenworthy@vermont.gov	(802) 241-0298
Sara Lane	Sara.Lane@vermont.gov	(802) 241-0299
Jessica Dalley	Jessica.Dalley@vermont.gov	(802) 241-0289

Agenda Items:

1. Review of Forms and Finalization of Forms
 - Live in Care Agreement
 - AFC Referral Form - CFC 706 (Language per legal & Procedure)
 - Enrollment/Disenrollment Form - CFC 707
 - AFC Manual (CFC Rights & Responsibilities)
2. Website Update (Placement of information and purging old links)
3. Self-Assessment - Questions?
4. Open Item - AFC Pre-Transition Payments
5. Open Item - Hospitalization Payments
6. What is a Quality Audit? (Policy Standards, Participant Record Review, Interviews and Participant Satisfaction)
7. Input on AFC Meetings - Likes/Dislikes?
8. Future of AFC - Education/Training Opportunities

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:13 AM
To: Lane, Sara
Subject: FW: AFC Phone Call - Monthly Meeting Minutes - April 6, 2017
Attachments: AFC Meeting Minutes_04.06.2017.docx; LTC Team List 3.23.17.doc

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>

From: Dalley, Jessica
Sent: Tuesday, April 11, 2017 1:46 PM
To: AHS - DAIL ASD LTCCC ; Alysia Chapman (alysiac@howardcenter.org) ; Amber Schaeffler (amber.schaeffler@ncssinc.org) ; Courcelle, Andre ; Bart Mair (bmair@lincolnstreetinc.org) ; Ben Gallagher (beng@howardcenter.org) ; Bonnie Jamieson (bjamieson@ucsvt.org) ; Brenda Donley (brendad@gmssi.org) ; Brent Hewey (bhewey@ccs-vt.org) ; Brown, Paula ; Corey Wilkins (cwilkins@hcrs.org) ; Coutu, Deb ; Danielle Boissy (danielleb@gmssi.org) ; David Wheeler (david@familiesfirstvt.com) ; Dawn Danner (DDanner@ucsvt.org) ; Currier, Debra ; Delaina Norton (delainan@howardcenter.org) ; Heather Goodale (hgoodale@csac-vt.org) ; Fossi, Herman ; Jane Munroe ; Jeanine Chalue (jeaninec@gmssi.org) ; Jennifer Murdoch (jmurdoch@csac-vt.org) ; Jessalyn Gustin (jgustin@uvs-vt.org) ; Dalley, Jessica ; Joan Carman ; Karen Ciechanowicz ; Kenworthy, Kathleen ; Katie Gilcris (kgilcris@hcrs.org) ; Kevin Burke (B1840house@aol.com) ; Kim Daniels (kdaniels@tds.net) ; Kim Lachant ; Kim McCarty (kmccarty@csac-vt.org) ; Laura Martin (lmartin@pridetbi.com) ; Laurie Fay (lfay@uvs-vt.org) ; Linda Ormsbee (lormsbee@comcast.net) ; Lisa Tilton (lisat@gmssi.org) ; Lorraine Gaboriault (lgaboriault@uvs-vt.org) ; Marie Greeno (MGreeno@ccs-vt.org) ; Marilyn Carter (marilync@gmssi.org) ; Corjay, Matthew ; Tierney-Ward, Megan ; Michel Kersten (mkersten@rmhscn.org) ; Michele Corrow (mcorrow@pridetbi.com) ; Michelle Dindo ; Nicole Pierce (npierce@hotmail.com) ; Paula Dougherty (pdougherty@csac-vt.org) ; Lane, Sara ; Sharon Tierra (stierra@csac-vt.org) ; Shirley Donohue (sdonohue@howardcenter.org) ; Nelson, Teresa ; Terri Lavelly (t.lavelly@nkhs.net) ; Ashe, William ; Woods, Mary
Cc: kwhite@lincolnstreetinc.org
Subject: AFC Phone Call - Monthly Meeting Minutes - April 6, 2017

Please find attached the AFC Monthly Phone Call Meeting Minutes for April 6, 2017 and the current LTC Team list for your reference.

If you have any questions, please feel free to contact me.

Thank you,

Jessica

Jessica R. Dalley

Administrative Assistant

Money Follows the Person Project

Department of Disabilities, Aging & Independent Living

Adult Services Division

280 State Drive, HC 2 South, Waterbury, VT 05671-2070

Main Line: (802) 241-0289

Fax: (802) 241-0385

Jessica.Dalley@vermont.gov

AFC Home Phone Call Meeting Minutes/Action Items

April 6, 2017

Introduction of the ASD Adult Family Care team and their roles:

AFC Field Co-ordination (Referrals, Enrollments & Transitions)	<i>Teresa Nelson</i>
HCBS Rules – Agency Self-Assessment / Participant Validation	<i>Andre Courcelle</i>
Meeting Co-ordination / Notes	<i>Jessica Dalley</i>
AFC Process Questions	<i>Matthew Corjay</i>
MFP Transition Funds Support / Billing Questions	<i>Kathleen Kenworthy</i>
Tier Rate Variances	<i>Sara Lane</i>
AFC Quality Reviews	<i>Andre Courcelle</i>
Billing Integrity	<i>Matthew Corjay</i>

Name	Email Address	Primary Phone Number
Teresa Nelson	Teresa.Nelson@vermont.gov	(802) 595-3706
Andre Courcelle	Andre.Courcelle@vermont.gov	(802) 786-2516
Matthew Corjay	Matthew.Corjay@vermont.gov	(802) 241-0286
Kathleen Kenworthy	Kathleen.Kenworthy@vermont.gov	(802) 241-0298
Sara Lane	Sara.Lane@vermont.gov	(802) 241-0299
Jessica Dalley	Jessica.Dalley@vermont.gov	(802) 241-0289

Pre-Service Dollars

Why aren't the agencies using pre-service dollars?

Discussion Topics:

- Time constraints
- Home development isn't assigned to a participant;
- Networking time may yield results
- Process needs to be simplified
- Medicaid dollars need to be tied to an individual
- Fee for service basis – challenges with electronic billing allowance of \$300 per day
- Outline of major issues – asking meeting participants to send e-mail.

Action Item:

1. *Jeanine Chalue, GMSS to send an e-mail to AFC team with a list of tasks regarding pre-service upon a new AFC consumer being placed within the agency.*
2. *AFC Team to review list for final pre-transition dollar payment policy*

Referral Form

AFC Informed Consent language, waiting on review and approval from legal team.

Home Upkeep

Good for up to six months

Covers Room & Board

Home Upkeep form signed by doctor, completed by facility upon facility admission or to help at discharge

Home upkeep amount = \$588 – deduction from patient share

Home upkeep applies to participants who have a patient share, (typically a client who is in a nursing home or ERC) used to maintain a home in the community

LTCCC or DCF can work with client to help apply for home upkeep

Can 94% & Home Upkeep be billed at the same time? Suggestion that information be put in SAMS for auditing purposes

Thirty-day rule still applies until further notice - Medicaid policy team is reviewing it

Action Item

1. Jessica Dalley to attach CFC/LTC Team List with contact info to April 6, 2017, meeting minutes.
2. All client specific questions related to home upkeep should be sent to the appropriate caseworker. Please refer to CFC/LTC Team List that is attached.

Transportation

DS has approximately \$6500 per year allowance for vehicles

CFC/AFC does not have this allowance

No Home Mods/Assistive device funding for AFC available – rolled into tier rate

Transportation needs/costs are expected to come out of tier rate

On a case by case basis, a variance may be requested

AFC Home – any transportation needs need to come out of the tier; at this time, there are no other options

ILA is outdated and needs revamping --- transportation is not covered

Items not covered in ILA can be presented to DAIL for possible variance

Review of all variances that have been done for the past 2-3 years for purposes of updating the ILA to cover the client's needs, create new tier rates

Home modifications are left up to the home provider

Clients are asking to bring PETS – can be a challenge finding an AFC Home

HCBS Provider Self-Assessment Forms

The surveys and e-mail went out on Monday April 3, 2017 --- sent out to directors/TBI contacts

Surveys are required for each program - AFC Provider, TBI Provider

Contact Andre Courcelle with questions regarding assessment

Due by April 28, 2017

Home Owners Seeking AFC Participants

Home owners that are clients do not want to relinquish their home to move into an AFC Home

Why can't care-taker move into the client's home?

Some homes already have all the modifications they need

3 AFC referrals that currently own their own homes

Once you move into an AFC home --- that becomes your "home" ---- because you can only have one home to be eligible for CFC.

Eligibility issues/concerns

Question to be added to the referral form: "Do you currently live in your own home?"

MFP funds are for participant – participant must agree to use \$2500.00 for home modifications

Client responsibility to maintain eligibility and qualify for AFC program (Medicaid/CFC)

AFC Meetings

Should the AFC Meetings continue after the May 4, 2017 – this is the end of current series of scheduled meetings?

How should meetings evolve, next steps?

Suggestion of an in-person meeting is preferable --- possibly a quarterly in person meeting

Meeting Attendees

Green Mountain Support Services – Jeanine Chaluc

Upper Valley Services – Joan Carman, Michelle Dindo

Lincoln Street Inc. – Bart Mair, Katie White

Counseling Service of Addison County – Sharon Tierra, Heather Goodale

Department of Aging and Independent Living (DAIL) – Deb Currier, Herman Fossi, Teresa Nelson, Deb Coutu, Jeanne Buley, Paula Brown, Matthew Corjay, Kathleen Kenworthy, Jessica Dalley, Mary Woods, Paulette Simard, David O'Vitt, Carol Wakeley, Mary Scarborough, Andre Courcelle

United Counseling Service – Kimberly Lachant

Legal Aid – Jane Munroe



Centers for Medicare & Medicaid Services

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Home and Community Based Services

Date 2014-01-10

Title Home and Community Based Services

For Immediate Release Friday, January 10, 2014

Contact press@cms.hhs.gov

Home and Community Based Services

Overview

The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.

Key Provisions of the Final Rule

1915(c) Home and Community-Based Waivers

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c) fact sheet at <https://www.medicare.gov/medicaid/hcbs/downloads/1915c-fact-sheet.pdf>.

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The final rule implements the section 1915(i) HCBS State Plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based services and to target services to specific populations. In addition, the final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. For more detail, please refer to the HCBS 1915(i) fact sheet at <https://www.medicare.gov/medicaid/hcbs/downloads/1915i-fact-sheet.pdf>.

Section 2601 of the Affordable Care Act: Five Year Period for Certain Demonstration Projects and Waivers

To simplify administration of the program for states, this final rule provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits. This provision allows states to use a five year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).

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The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid home and community-based services to provide alternatives to services provided in institutions. For more detail, please refer to the HCBS Settings fact sheet at <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-setting-fact-sheet.pdf>.

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. New 1915(c) waivers or 1915(i) State plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) State plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) State plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress towards compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan that provides for the delivery of HCBS services within settings meeting the final rule's requirements, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances.

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In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

CMS.gov

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Home & Community Based Services Guidance

The Centers for Medicaid and CHIP Services (CMCS) Division of Long Term Services and Supports (DLTSS) issues technical assistance as part of the state-federal partnership in administering the Medicaid programs. We use this guidance, in the form of letters to State Medicaid Directors, Informational Bulletins, Issue Briefs, and Frequently Asked Questions, to communicate with states and other stakeholders regarding operational issues related to home and community based services (HCBS).

Technical assistance is available from CMS to assist state Medicaid agencies in developing, enhancing, implementing, and evaluating HCBS.

HCBS Training Series

The [HCBS Training Page](#) provides webinar trainings which were presented during State Operations and Technical Assistance (SOTA) calls. These webinars focused on a variety of topics such as Home and Community Based settings requirements, the Heightened Scrutiny Process, Fiscal Integrity with a focus on Personal Care Services, and Conflict of Interest.

Related Links

[HCBS Technical Assistance for States](#)

[HCBS Training Series](#)

[1915\(c\) Technical Guidance](#)

Guidance

HCBS Final Regulation

HCBS Settings


Electronic Visit Verification


Additional Resources

HCBS Health & Welfare

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

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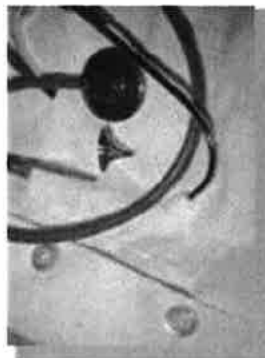


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7500 Security Boulevard Baltimore, MD 21244



Person-Centered Planning

Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Regulatory Requirement

- Required for both the 1915(c) and the 1915(i)
- For the 1915(c)
 - Requirements for the person-centered planning process can be found at 441.301(c)(1)(ix)
 - Requirements for the person-centered service plan can be found at 441.301(c)(2)(xiii A through H)
 - Requirements for review of the person-centered plan can be found at 441.301(c)(3)

Regulatory Requirements

- For the 1915(i)
 - Requirements for the person-centered process and plan can be found at 441.725(a) and (b)
- The process and plan requirements are the same for both authorities.

Process and Plan

- Each individual will be engaged in a person-centered planning process, which will lead to the development of their person-centered service plan.

Person-Centered Planning Process

Leading

- The individual will lead the person-centered planning process where possible.
- The process should provide 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 Process

Leading

- The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative.
 - All references to individuals include the role of the individual's representative.
- The planning process should only include people chosen by the individual.

Person-Centered Planning Process

Requirements

The person-centered planning process should be characterized by the following:

- Is timely and occur at times and locations of convenience to the individual.
- Reflects cultural considerations of the individuals.
- Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

Person-Centered Planning Process

Conflict Resolution

- The person-centered planning process should include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

Person-Centered Planning Process

Conflict-of-Interest

- 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.
- Exceptions to this will only be granted when the State demonstrates that the only willing and qualified entity to provide case management or develop person-centered service plans in a geographic area also provides HCBS.

Person-Centered Planning Process

Conflict-of-Interest

- 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.

Person-Centered Planning Process

Informed Choices & Updates

The planning process must:

- Offer informed choices to the individual regarding the services and supports they receive and from whom.
- Record the alternative home and community-based settings that were considered by the individual.
- Include a method for the individual to request updates to the plan as needed.

Person-Centered Service Plan

- The person-centered service plan must 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 support.
- The written plan must reflect that the setting in which the individual resides is chosen by the individual.

Person-Centered Service Plan

Community Access

- The State must ensure that the setting chosen by the individual 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
 - Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Person-Centered Service Plan *Requirements*

The person-centered service plan must:

- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired outcomes.
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

Person-Centered Service Plan

Services & Supports

The person-centered service plan must:

- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and providers of those services and supports, including natural supports.
- Natural supports are unpaid supports that are provided voluntarily to the individual voluntarily in lieu of 1915(c) HCBS waiver services and supports.

Person-Centered Service Plan

Services & Supports

The person-centered service plan must:

- Include those services, the purpose or control of which the individual elects to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.

Person-Centered Service Plan

Understandability

- The person-centered service plan must 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.

Person-Centered Service Plan

Monitoring, Finalizing, & Distributing

The person-centered service plan must:

- Identify the individual and/or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individual and providers responsible for its implementation.
- Be distributed to the individual and other people involved in the plan.

Person-Centered Service Plan *Modifications*

- Any modifications of these conditions must be supported by a specific assessed need and justified in the person-centered service plan.

Person-Centered Service Plan *Modifications*

The following requirements must be documented in the person-centered service plan:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.

Person-Centered Service Plan *Modifications*

The following requirements must be documented in the person-centered service plan:

- Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Person-Centered Service Plan *Review*

- The person-centered service plan must be reviewed, and revised upon reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

Choices for Care: Long-Term Care Team Staff

DVHA has additional staff devoted to LTC financial eligibility. If you are unable to resolve your issues with the Benefits Program Specialist or their Supervisor, you now have the additional sources below:

Long Term Care Medicaid Program Director

Michele Betit
Michele.Betit@vermont.gov
Phone: 802-479-8669

LTC Benefits Program Administrator

Ann Hastings
Ann.Hastings@vermont.gov
Phone: 802-476-1640
Fax: 802-476-1654

LTC Medicaid Health Care Assistant Administrator II

Sarah Fong
Sarah.Fong@vermont.gov
Phone: 802-769-2375
Fax: 802-769-1737

LTC Medicaid Health Care Assistant Administrator II

Lisa Racine
Lisa.Racine@vermont.gov
Phone: 802-334-1559
Fax: 802-334-3386

Choices for Care: Long-Term Care Team Staff

District Office	Name	Office Phone	Address	Email address	Supervisor	Transition Coordinators (Supervised by: Deb Coutu, RN)	TC Phone Number	DVHA Benefits Processing Specialist	Office Phone	Supervisor
Barre	David O'Vitt, RN	(802) 476-1646 FAX: 479-4297	McFarland State Office Building 5 Perry St., Suite 150 Barre, VT 05641	David.Ovitt@vermont.gov	Mary Woods, RN	Herman Fossi, RN	Office: (802) 871-3360 Cell: (802) 595-1858 FAX: 871-3052	Melissa Richardson A-K Christine Sundquist L-Z	479-8536 476-1636	Debbie Greeno 786-5965
Bennington	Stephanie Clarke, RN	(802) 447-2850 FAX: 447-8307	200 Veterans' Memorial Dr. Suite 6 Bennington, VT 05201	Stephanie.Clark@vermont.gov	Mary Woods, RN	Debra Currier, RN	Office: (802) 288-8018 Cell: (802) 585-5889 FAX: 871-3052	Jayne Rogers A-Mc Roberta Caslin Mid-Z	447-6999 447-2479	Debbie Greeno 786-5965
Brattleboro	George Jurasinski, RN	(802) 251-2118 FAX: 254-6394	232 Main St., P.O. Box 70 Brattleboro, VT 05302-0070	George.Jurasinski@vermont.gov	Mary Woods, RN	Herman Fossi, RN	Office: (802) 871-3360 Cell: (802) 595-1858 FAX: 871-3052	Joshua May A-Z	769-2553	Sarah Fong 769-2375
Burlington	Jeanne Buley, RN Brenda Smith, RN **Temp/float: Lorraine Wargo, RN	(802) 871-3058 FAX: 878-1793	Mail: NOB 1 South, 280 State Dr. Waterbury, VT 05671-1010 Physical: 312 Hurricane Lane Williston, VT 05495	Jeanne.Buley@vermont.gov Brenda.Smith@vermont.gov Lorraine.Wargo@vermont.gov	Paula Brown, RN	Debra Currier, RN	Office: (802) 288-8018 Cell: (802) 585-5889 FAX: 871-3052	Alyssa Adams A-Cor Carol Hagggett Cos-Deg Nicky Thibault Deh-Lan Denise Hughes Lao-Q Lynn Labonte R-Z	652-6842 479-8554 769-2571 769-2337 652-6848	Sarah Fong Lottie Lavallette 769-2337 Debbie Greeno 786-5965
Hartford	Chris Malone, RN	(802) 296-5592 FAX: 295-4148	118 Prospect Street, Suite 401 White River Junction, VT 05001	Christopher.Malone@vermont.gov	Mary Woods, RN	Herman Fossi, RN	Office: (802) 871-3360 Cell: (802) 595-1858 FAX: 871-3052	Sara Jane Murphy A-Z	295-4125	Debbie Greeno 786-5965
Middlebury	Mary Scarborough, RN	(802) 388-5730 FAX: 388-1965	156 South Village Green, Suite 201 Middlebury, VT 05753	Mary.Scarborough@vermont.gov	Paula Brown, RN	Debra Currier, RN	Office: (802) 288-8018 Cell: (802) 585-5889 FAX: 871-3052	Susan Winston A-Z	388-5384	Debbie Greeno 786-5965
Morrisville	Maura Krueger, RN	(802) 888-0510 FAX: 888-0536	63 Professional Dr. Suite 4 Morrisville, VT 05661	Maura.Krueger@vermont.gov	Mary Woods, RN	Teresa Nelson	Cell: (802) 595-3706 FAX: (802) 766-3010	Kate Chase A-Z	888-0511	Lottie Lavallette 769-2337
Newport	Paulette Simard, RN	(802) 334-3910 FAX: 334-4818	100 Main St., Suite 240 Newport, VT 05855	Paulette.Simard@vermont.gov	Paula Brown, RN	Teresa Nelson	Cell: (802) 595-3706 FAX: (802) 766-3010	Kiel Santelli A-F Megan Grenier G-Z	527-3944 334-1728	Lottie Lavallette 769-2337 Lisa Racine 334-1559
Rutland	Celine Aprilliano, RN	(802) 786-5971 FAX: 770-1825	320 Asa Bloomer Building Rutland, VT 05701	Celine.Aprilliano@vermont.gov	Mary Woods, RN	Debra Currier, RN	Office: (802) 288-8018 Cell: (802) 585-5889 FAX: 871-3052	Lynn Labonte A-B Melody Shaw C-K Kerry Collins L-Z	652-6848 786-5968 786-1519	Debbie Greeno 786-5965
Springfield	Carol Wakeley, RN	(802) 289-0695 FAX: 885-8879	100 Mineral Street, Suite 201 Springfield, VT 05156	Carol.Wakeley@vermont.gov	Mary Woods, RN	Herman Fossi, RN	Office: (802) 871-3360 Cell: (802) 595-1858 FAX: 871-3052	Ariani Szkyler A-E Melissa Richardson F-J Christine Sundquist K-M Ariani Szkyler N-Z	257-2567 479-8536 476-1636 257-2567	Debbie Greeno 786-5965
St. Albans	Kate Dempsey, RN **Lorraine Wargo, RNC (Grand Isle/So. Hero)	(802) 524-7913 FAX: 527-4078 ** (871-3058)	27 Federal Street, Suite 400 St. Albans, VT 05478	Kate.Dempsey@vermont.gov Lorraine.Wargo@vermont.gov	Paula Brown, RN	Teresa Nelson	Cell: (802) 595-3706 FAX: (802) 766-3010	Sarah Early A-L Kiel Santelli M-Z	527-3967 527-3944	Lottie Lavallette 769-2337
St. Johnsbury	Julie Bigelow, RNC Pam Brainard, RN	(802) 585-5360 (802) 748-8361 FAX: 751-2644	67 Eastern Ave, Suite 7 St. Johnsbury, VT 05819	Julie.Bigelow@vermont.gov Pamela.Brainard@vermont.gov	Paula Brown, RN	Teresa Nelson	Cell: (802) 595-3706 FAX: (802) 766-3010	Nicole Hammel A-Z	751-0604	Lisa Racine 334-1559

CFC Program Manager	CFC Program Supervisor (NORTH)	CFC Program Supervisor (SOUTH)	CFC TC Supervisor	Moderate Needs Group	Attendant Services Program	Money Follows the Person
Sara Lane, RN Sara.Lane@vermont.gov HC 2 South 280 State Drive Waterbury, VT 05671-2070 Phone 241-0299/Fax 241-0385 Cell 540-5704	Paula Brown, RN Paula.Brown@vermont.gov HC 2 South 280 State Drive Waterbury, VT 05671-2070 Phone 241-0283/Fax 241-0385 Cell 585-9245	Mary Woods, RN Mary.Woods@vermont.gov HC 2 South 280 State Drive Waterbury, VT 05671-2070 Cell 296-1630 Fax 241-0385	Deb Coutu, RN Deb.Coutu@vermont.gov HC 2 South 280 State Drive Waterbury, VT 05671-2070 Phone 241-0364/Fax 241-0385 Cell 917-8077	Mary Collins, Ind. Living Svcs. Mary.Collins@vermont.gov 100 Main St., Suite 200 Montpelier, VT 05602 Phone: 828-0610 Fax: 828-0599	Matt Corjay, Project Director Matthew.Corjay@vermont.gov HC 2 South 280 State Drive Waterbury, VT 05671-2070 Phone: 241-0286 Fax: 241-0385	



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In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.



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Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:12 AM
To: Lane, Sara
Subject: FW: HCBS Rules: Person Centered Planning and Settings Information

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>

From: Lane, Sara
Sent: Friday, April 28, 2017 3:57 PM
To: Malone, Christopher
Subject: Re: HCBS Rules: Person Centered Planning and Settings Information

It was a great question! Have a nice weekend!

Sara Lane, BSN, RN
Aging and Disabilities Program Manager
DAIL-Adult Services Division
HC 2 280 State Dr.
Waterbury, VT 05671-2070
Phone: 802.241-0299
Fax: 802.241.0385
Email: sara.lane@vermont.gov

From: Malone, Christopher
Sent: Friday, April 28, 2017 3:54 PM
To: Lane, Sara
Subject: RE: HCBS Rules: Person Centered Planning and Settings Information

Sorry for the generic question, realized after I sent how vague it was. Understand CMS has been a little slow approving other states transition plans.
This information is real good.
Thank you so much

Have a good weekend

Chris

Christopher P. Malone RN

LTCCC-Long Term Care Clinical Coordinator

DAIL/Choices for Care program

118 Prospect Street, Suite 401

White River Junction, Vermont 05001

Ph.802-296-5592

Fax-802-295-4148

Email-christopher.malone@vermont.gov



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

From: Lane, Sara

Sent: Friday, April 28, 2017 3:49 PM

To: Malone, Christopher <Christopher.Malone@vermont.gov>

Subject: Re: HCBS Rules: Person Centered Planning and Settings Information

I believe so, as Andre was working with AHS regarding the provider assessments etc.

Sara Lane, BSN, RN

Aging and Disabilities Program Manager

DAIL-Adult Services Division

HC 2 280 State Dr.

Waterbury, VT 05671-2070

Phone: 802.241-0299

Fax: 802.241.0385

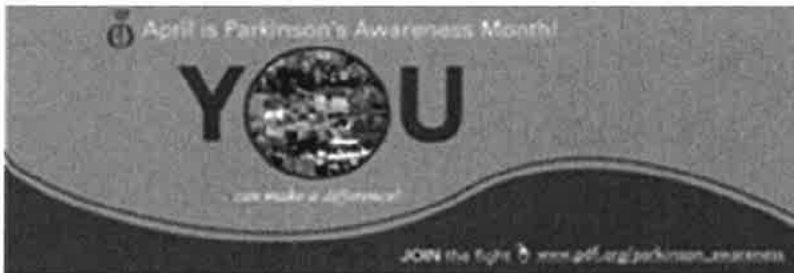
Email: sara.lane@vermont.gov

From: Malone, Christopher
Sent: Friday, April 28, 2017 3:12 PM
To: Lane, Sara
Subject: RE: HCBS Rules: Person Centered Planning and Settings Information

Hi Sara,
Has our plan been accepted by CMS yet?

Chris

Christopher P. Malone RN
LTCCC-Long Term Care Clinical Coordinator
DAIL/Choices for Care program
118 Prospect Street, Suite 401
White River Junction, Vermont 05001
Ph:802-296-5592
Fax-802-295-4148
Email-christopher.malone@vermont.gov



NEED ASSISTANCE?

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- 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

From: Lane, Sara
Sent: Friday, April 28, 2017 2:58 PM
To: AHS - DAIL ASD LTCCC <AHS.DAILASDLTCCC@vermont.gov>
Cc: Brown, Paula <paula.brown@vermont.gov>; Woods, Mary <Mary.Woods@vermont.gov>; Coutu, Deb <Deb.Coutu@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>; Corjay, Matthew <Matthew.Corjay@vermont.gov>
Subject: HCBS Rules: Person Centered Planning and Settings Information

At our April LTC Team meeting Andre provided an update on the work to implement the Home and Community Based Services (HCBS) Rules specific to person centered planning and settings.

As a recap, work has been done with various provider groups: Adult Day, Case Managers, Authorized Agencies for AFC, TBI to work together to integrate the HCBS rule language into the respective provider standards or policies/procedures. (DS has also done this with their network) These rules do not officially go into effect until 2019. The next step is for the various provider groups to complete a self assessment to determine where they need to strengthen compliance with the HCBS rules. When the self assessments are completed, there will be a validation of the assessments by way of interviewing the recipients/participants of the service providers. The compliance and practice of the HCBS rules will be ensured through quality reviews for each provider group.

Keep in mind that the HCBS rules do not apply to our Residential Care and Assisted Living Providers as they are not considered an HCBS setting by CMS. CMS identifies them as a PNMI- Private Non-Medical Institution. With this said philosophically we support the settings and person centered planning rules, so when we are able to re-open the regulations for these provider types, we can work with the providers to incorporate some of the rules into the regulations.

Some of you asked about resources for person centered planning, so you can start integrating/sharing elements of this practice with your waiver teams.

Below are links to information/resources for both person centered planning and settings rules. I also attached a document, as well. Happy reading and let me know if any questions come up for you.

<https://acl.gov/Programs/CPE/OPAD/docs/Person-Centered-Planning-and-HCBS.pdf>

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-10-2.html>

<https://www.medicaid.gov/medicaid/hcbs/guidance/index.html>

-Sara

Sara Lane, BSN, RN
Aging and Disabilities Program Manager
 DAIL-Adult Services Division
 HC 2 280 State Dr.
 Waterbury, VT 05671-2070
 Phone: 802.241-0299
 Fax: 802.241.0385
 Email: sara.lane@vermont.gov

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:15 AM
To: Lane, Sara
Subject: FW: HCBS Rules Settings Guidance
Attachments: Exit Seeking Behavior and Compliance with HCBS Settings Rules_CMS.pdf

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>

From: Lane, Sara
Sent: Friday, December 16, 2016 11:08 AM
To: Brown, Paula ; Woods, Mary ; Corjay, Matthew ; Courcelle, Andre
Subject: HCBS Rules Settings Guidance

This may be good to share with our AA's for AFC, if they have not seen it already.

-S

Sara Lane, BSN, RN
Aging and Disabilities Program Manager
HC 2 South, 280 State Drive
Waterbury, VT 05671
Phone: (802) 241.0299
Fax: (802) 241-0385
Email: sara.lane@vermont.gov

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



FAQs concerning Medicaid Beneficiaries in Home and Community-Based Settings who Exhibit Unsafe Wandering or Exit-Seeking Behavior

December 15, 2016

The regulation issued by the Centers for Medicare & Medicaid Services (CMS) on January 16, 2014¹ finalized the criteria for home and community-based settings for the purposes of Medicaid funding. Applying to services authorized under 1915(c) home and community-based services (HCBS) waivers, and 1915(i) HCBS and 1915(k) Community First Choice state plan options, the criteria require settings receiving HCBS funding to facilitate beneficiary independence and decision-making in defining desired integration into their communities. As states, providers, beneficiaries and other stakeholders determine a strategy for complying with the setting requirements during a transition period that ends March 17, 2019, questions have arisen on how to adhere to the individualized nature of service provision for individuals with dementia or other conditions in which unsafe wandering or exit-seeking behavior is exhibited. The following guidance begins with an articulation of how regulatory requirements can be met by settings providing HCBS to individuals with such behavior, and concludes with describing some options for HCBS stakeholder education and consideration.

Q1: How can residential and adult day settings comply with the HCBS settings requirements while serving Medicaid beneficiaries who may wander or exit-seek unsafely?

A1: Many Medicaid beneficiaries living with dementia and other conditions can have a heightened risk of wandering, or attempting to leave a setting (exit-seeking) unsafely. These behaviors are not necessarily constant or permanent.

Wandering occurs in ways that may appear aimless but often have purpose. People may wander simply because they want to move. Sometimes wandering responds to an unmet basic need like human contact, hunger, or thirst; a noisy or confusing environment; or because people are experiencing some type of distress, like pain or the need to use the toilet. Wandering can be helpful or dangerous, depending on the situation. Although people who wander may gain social contact, exercise, and stimulation, they can also become lost or exhausted.²

Person-centered planning, staff training and care delivery are core components of provider operations to meet HCBS requirements while responding to unsafe wandering and exit-seeking behavior in an individualized manner.³ Person-centered services involve knowing individuals, and their conditions, needs, and history and using this knowledge to create strategies to assure that individuals are free to interact with others and the community in the most integrated way possible and still prevent injury for those who wander or exit-seek unsafely. Home and

¹ <https://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

² Tilly, J., & Reed, P., (2009) Dementia Care Practice Recommendations for Assisted Living and Nursing Homes, Phases 1 & 2. Alzheimer's Association.

³ Required and defined in regulation for 1915(c) at 42 CFR §441.301(c)(1), for 1915(i) at 42 CFR §441.725, and for 1915(k) at 42 CFR §441.540.

community-based settings must demonstrate that person-centered planning drives their operations and services for each person. The beneficiaries the settings serve must drive the person-centered planning process with assistance from a trained, competent, assessor, care manager or similar facilitator. The beneficiary should be able to get input from people who are important to him or her, while still reflecting the individual's input as much as possible. Person-centered plans and related decisions should be consistent with the person's needs and preferences, and informed by family members, caregivers, and other individuals that the beneficiary has identified as playing an important role in his or her life. The role of person-centered planning and the process for realizing this role is described in the final HCBS regulation and in guidance found on the Medicaid.gov website.

Person-centered service plans should be developed with the individual, and include their representatives as appropriate. The person-centered planning process should include a process that:

- is informed by discussions with family members or other individuals who are important to them about key aspects of daily routines and rituals;
- focuses on an individual's strengths and interests;
- outlines the individual's reaction to various communication styles;
- identifies the individual's favorite things to do and experience during the day, as well as experiences that contribute to a bad day;
- proposes experiences that the person may enjoy as community engagement, and describes those factors or characteristics that the individuals would find most isolating or stigmatizing.

To promote effective communication, which is at the core of person-centered planning and service delivery, provider staff serving beneficiaries who wander or exit-seek should receive education and training about how to communicate with individuals living with conditions that may lead to unsafe wandering or exit-seeking. Training programs may include important information on issues such as:

- The most common types of conditions, diseases and disorders that lead to wandering behavior; the various stages of key conditions that result in increased risk of wandering and what to expect over time; and the potential impact of these conditions on the individual's ability to function.
- Differentiating between most common types of conditions, diseases and disorders that lead to wandering behavior from serious mental illness or adverse environmental conditions such as overmedication or neglect.
- Assessing individuals for co-occurring conditions (including barriers to sufficient adaptive skills and the ability to communicate with others) that increase risk for unsafe wandering or exit-seeking.
- Understanding situations that led to past instances of unsafe wandering or exit-seeking or the desire to engage in them;
- Principles of person-centered care planning and service delivery;
- Strategies for identifying and handling behavioral expressions of need or distress.

In addition to previous guidance provided by CMS on the implementation of person-centered planning requirements outlined in the federal HCBS regulations defining home and community-

based settings, integration of the following promising practices around person-centered planning specifically for people who wander or exit-seek unsafely is recommended:

- Assessing the patterns, frequency, and triggers for unsafe wandering or exit-seeking through direct observation and by talking with the person exhibiting such behaviors, and, when appropriate, their families.
- Using this baseline information to develop a person-centered plan to address unsafe wandering or exit-seeking, implementing the plan, and measuring its impact.
- Using periodic assessments to update information about an individual's unsafe wandering or exit-seeking, and adjust the person-centered plan as necessary.

Q2: Can provider-controlled settings with Memory Care Units with controlled-egress comply with the new Medicaid HCBS settings rule? If so, what are the requirements for such settings?

A2: Yes, but only if controlled-egress is addressed as a modification of the rules defining home and community-based settings, with the state ensuring that the provider complies with the requirements of 42 C.F.R. 441.301(c)(4)(F), 441.530(a)(vi)(F) and 441.710(a)(vi)(F). Any setting using controlled-egress should assess an individual that exhibits wandering (and the underlying conditions, diseases or disorders) and document the individual's choices about and need for safety measures in his or her person-centered care plan. The plan should document the individual's preferences and opportunities for engagement within the setting's community and within the broader community.

Settings with controlled-egress should be able to demonstrate how they can make individual determinations of unsafe exit-seeking risk and make individual accommodations for those who are not at risk. Should a person choose a setting with controlled-egress, the setting must develop person-centered care plans that honor autonomy as well as minimize safety risks for each person, consistent with his or her plan goals. For example, spouses or partners who are not at risk for exit-seeking and who reside in the same setting should have the ability to come and go by having the code to an electronically controlled exit. Technological solutions, such as unobtrusive electronic pendants that alert staff when an individual is exiting, may be used for those at risk, but may not be necessary for others who have not shown a risk of unsafe exit-seeking. Importantly, such restrictions may not be developed or used for non-person-centered purposes, such as punishment or staff convenience.

In situations where a setting uses controlled-egress on an individual basis to support individuals who wander or exit-seek unsafely, consistent with our regulations, the person-centered plan must document the individual's:

- Understanding of the setting's safety features, including any controlled-egress,
- Choices for prevention of unsafe wandering or exit-seeking
- Consent from the individual and caregivers/representatives to controlled-egress goals for care
- Services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility
- Options that were explored before any modifications occurred to the person-centered plan

Regulations require the person-centered plan to be reviewed at least annually with the Medicaid beneficiary and his or her representative, to determine whether it needs revision⁴. If a secured memory unit is no longer necessary to meet the individual's needs, the individual must be afforded the appropriate services in that setting to integrate into the community and exercise greater autonomy as well as being offered the option of a setting that does not have controlled egress.

To assure fidelity in complying with the regulations defining home and community-based settings, Memory Care Units should attempt to implement as many options as possible that are outlined within this guidance regarding staffing, activities and environmental design to assure optimal community integration for HCBS beneficiaries.

Note that the regulations provide that Medicaid beneficiaries receiving services in home and community-based settings must be free from coercion and restraint. Consistent with this, home and community-based settings should not restrict a participant within a setting, unless such restriction is documented in the person-centered plan, all less restrictive interventions have been exhausted, and such restriction is reassessed over time.

Q3: What are some promising practices that HCBS settings use to serve people who are at risk of unsafe wandering or exit-seeking?

A3: Person-centered planning is at the core of all promising practices. That said, there are staff, activity, and environmental design approaches, as described below, which could be part of an individual's person-centered plan in response to unsafe wandering and exit-seeking. These promising practices have been compiled from industry and governmental sources⁵ and are offered as suggestions as they do not constitute requirements for HCBS services or providers.

Staffing:

- Ensure that staff have adequate training in person-centered planning and unsafe wandering or exit-seeking, including how to effectively engage and participate with individuals in both planned and spontaneous activities as well as strategies for addressing the underlying needs and preferences that may motivate wandering or exit seeking.
- Support individuals to move about freely with staff who help individuals walk or leave the room safely (e.g., providing a walking companion).
- Ensure adequate staffing for activities outside the facility.
- Ensure staff regularly escorts individuals to locations and activities outside of the setting as outlined in the person-centered services plan.

⁴42 CFR 441.301(c)(3) for 1915(c); 42 CFR 441.725(c) for 1915(i); and 42 CFR 441.540(c) for 1915(k).

⁵ See the Alzheimer's Association's Dementia Care Practice Recommendations at http://www.alz.org/professionals_and_researchers/dementia_care_practice_recommendations.asp, an issue brief from the Administration for Community Living titled "Responding to the Wandering Behavior of People with Dementia" in the Dementia section at http://www.acl.gov/Get_Help/BrainHealth/Index.aspx, and the Center on Excellence in Assisted Living guidance on this topic at <http://www.theceal.org/>

- Provide flexible supervision to assure adequate support from resident to resident and from time to time for the same resident dependent upon need.

Activities:

- Prevent under-stimulation by offering activities that engage the beneficiary's interest. Activities could include music, art, physical exercise, mental stimulation, therapeutic touch, pets, or gardening.
- Provide a wellness program to help people exercise, have a healthy diet, manage stress, improve balance and gait, and stimulate cognition.
- Support mobility through engaging activities, such as dog walking, gardening, yoga, and dance.
- Develop daily meaningful activities and minimize passive entertainment, such as television watching.
- Make available easily accessible activities, such as playing cards, reading books and magazines.
- Encourage interaction with others.
- Ensure that family and friends have unrestricted access to the individual if she or he wants this, and to the setting itself.

Environmental design:

- Eliminate overstimulation, such as visible doors that people use frequently; noise; and clutter.
- Create pictures on walls that can be sensory in nature to give individuals a place to stop and experience through sight or touch.
- Manage shift changes so that individuals do not see significant numbers of staff coming and going through the exit/entrance door at the same time.
- Use signage to orient the individual to the environment, such as indicating where toilets and bedrooms are, and assuring that there are places for individuals to sit and rest in large spaces within a setting that allow for safe wandering.
- Disguise exit doors using murals or covering door handles as safety codes permit.
- Use unobtrusive technological solutions, such as installing electronic coding lock systems on all building exits, or having individuals who wander or exit-seek unsafely wear electronic accessories that monitor their location.
- Include lockable doors on each individual's room unless the resident's person-centered plan documents that such an arrangement is unsafe, following the requirements of the rule on individual modifications. Alternative features designed for safety, such as doors on living units that are not lockable or secure exits, should be used only when they are part of the resident's person-centered plan, after less intrusive methods have been tried and did not work, as provided in the rule.
- Ensure unrestricted access to secured outdoor spaces and a safe, uncluttered path for people to wander, which has points of interest and places to rest.
- Identify quiet, public spaces for individuals to sit, observe and rest while simultaneously being part of the community, and may include items that are used to soften the senses or help with removing sensory stimulation.

- Enable people to leave the premises when they are not at risk of doing so unsafely. For example, wearable technologies can give people the ability to leave the setting or can limit the unsafe exiting of residents whose person-centered plans document that they are at risk of doing so.
- Using tools and technology to monitor an individual's activities to promote optimal independence and personal autonomy, but assuring that such resources are not used in place of adequate supervision.
- Ensure that Medicaid beneficiaries who may wander or exit-seek unsafely carry identification with their name and the service provider's location and contact information.
- Create a back-up plan or lost-person plan that describes roles and responsibilities when an individual has exited in an unsafe manner.
- Evaluate each lost-person incident to make revisions to person-centered care plans or to environmental design as necessary.

Q4: How can residential and adult day settings promote community integration for people who are at risk of unsafe wandering or exit-seeking? What are some examples of promising practices for implementing the community integration requirements of the regulations defining home and community-based settings and simultaneously assuring the safety of individuals who exhibit these behaviors?

A4: All settings must facilitate and optimize Medicaid beneficiaries to live according to their daily routines and rituals, pursue their interests, and maximize opportunities for their engagement with the broader community in a self-determined manner, as outlined in the individual's person-centered service plan. The plan must reflect clinical and support needs as identified through an assessment of functional need, and document the individual's preferences for community integration and how these preferences will be addressed in the setting they have chosen.

Settings can support community integration, in accordance with each individual's person-centered plan by strategies and practices such as:

- Finding out during initial assessments what individuals desire in terms of community engagement and educate them about how the setting's capabilities will meet the individual's needs and preferences. This should be done before the individual makes a decision about services and settings to allow the best fit between the person and place.
- Documenting the factors the person identifies as important in a community such as proximity to and involvement of family, connections to communities of faith, specific cultural resources and activities, and others.
- Recording individual preferences for community integration in the person-centered plan and how the setting will support those preferences (e.g., participating in their faith community, attending a favorite club, Sunday breakfast at the local diner, interests in volunteering or in working, etc.) as well as the transportation needed to achieve desired outcomes, recognizing that many of these activities are leveraged through natural supports and thus would not require Medicaid-funded resources.
- Providing individuals with opportunities to engage others in their settings through activities, outings, and socialization opportunities.

- Providing sufficient staff and transportation to enable individuals' participation in their activities of choice in the broader community. These could include opportunities for work, cultural enjoyment, worship, or volunteering. The person-centered service plan may also include provider-facilitated opportunities to engage in desired activities in the broader community.
- Ensuring that visitors are not restricted, and individuals can connect to their virtual communities of choice through social media noting that this alone does not substitute for community activities and integration.
- Ensuring that individuals have opportunities to visit with and go out with family members and friends, when they want this. Providing an inviting environment and flexible schedules and service times (e.g., meals, medication administration) can encourage family and friends' participation in the life of the residential setting and support their efforts to maintain individuals' connections to the external community.
- Reviewing at least annually whether any parts of the person-centered plan need change. It is important to note that the modifications requirement within the regulations defining home and community-based settings also applies to anyone in a residential or non-residential setting, and thus the person-centered plan needs to document what services and supports should be made available to allow people to live where they want and do what they want during the day to assure maximum integration with the broader community. For more information on the HCBS rule requirements on person-centered planning, please refer to CMS' previous FAQs on this topic.

All settings, including those in rural communities and those in low density suburban areas, are encouraged to provide adequate transportation opportunities to meet beneficiaries' desires for meaningful community engagement and participation in typical community activities.

Note that visits by community members have value but do not substitute for community access for Medicaid beneficiaries receiving services in residential and adult day settings.

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:13 AM
To: Lane, Sara
Subject: FW: Head up: HCBS provider self-assessment going out next week
Attachments: Consolidated_Povider_Table 2017.xls
Importance: High

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>

From: Tierney-Ward, Megan
Sent: Thursday, March 30, 2017 4:18 PM
To: AHS - DAIL ASD Central Office Staff
Subject: Head up: HCBS provider self-assessment going out next week
Importance: High

Good afternoon,
 This is a heads up that our Choices for Care and TBI providers will receive an email communication on Monday April 3rd asking them to complete a self-assessment survey regarding the federal HCBS regulations. The deadline for completion is April 28th. Each provider will be asked to complete one survey for each HCBS program. For example, if a provider does both Choices for Care and TBI services, they will get two messages asking them to complete a survey for each program.

Below is a sample message that will accompany the communication and survey link:

Hello,
 As a valued member of our Choices for Care 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.***

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

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.
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

Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:13 AM
To: Lane, Sara
Subject: FW: Head up: HCBS provider self-assessment going out next week

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>

From: Tierney-Ward, Megan
Sent: Friday, March 31, 2017 11:35 AM
To: AHS - DAIL ASD Central Office Staff
Subject: RE: Head up: HCBS provider self-assessment going out next week

In case you want to see the survey, the link to a PDF version is on our website.

<http://asd.vermont.gov/news/hcbs-provider-self-assessment-survey-implementation>

From: Tierney-Ward, Megan
Sent: Thursday, March 30, 2017 4:18 PM
To: AHS - DAIL ASD Central Office Staff <AHS.DAILASDCentralOfficeStaff@vermont.gov>
Subject: Head up: HCBS provider self-assessment going out next week
Importance: High

Good afternoon,

This is a heads up that our Choices for Care and TBI providers will receive an email communication on Monday April 3rd asking them to complete a self-assessment survey regarding the federal HCBS regulations. The deadline for completion is April 28th. Each provider will be asked to complete one survey for each HCBS program. For example, if a provider does both Choices for Care and TBI services, they will get two messages asking them to complete a survey for each program.

Below is a sample message that will accompany the communication and survey link:

Hello,

As a valued member of our Choices for Care 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.***

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

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HCBS PROVIDER SELF-ASSESSMENT SURVEY IMPLEMENTATION

31 MARCH 2017

ASD is happy to announce that the Provider Self-Assessment Survey for the new federal Home & Community-Based Services Medicaid (HCBS) regulations is ready for distribution! Providers of Choices for Care Case Management, Adult Family Care and Traumatic Brain Injury (TBI) have been notified that the survey will be distributed April 3rd and is due April 28th. Responses to the survey will help us better understand how our providers' current operations align with the new federal HCBS rules, and how we can work together to make any necessary changes.

- [DAIL HCBS Provider Self-Assessment Survey Tool - PDF](#)
(/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf)
- [Information and Guidance on the Federal Rules](#) (<https://hcbsadvocacy.org/learn-about-the-new-rules/>)
- [Information on the Choices for Care and TBI Program Work Plan](#)
(<http://asd.vermont.gov/special-projects/federal-hcb>)

TAGS:

[Choices for Care \(/tags/choices-care\)](#) |[Long Term Services and Supports \(/tags/long-term-services-and-supports\)](#) |[Quality \(/tags/quality\)](#) | [TBI \(/tags/tbi\)](#) |[Traumatic Brain Injury \(/tags/traumatic-brain-injury\)](#)

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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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.medicare.gov/medicaid/hcbs/guidance/index.html>)

Program Documents & Tools

- [DAIL Provider Self-Assessment Survey \(/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf\)](/sites/asd/files/documents/DAIL_HCBS_Provider_Self-Assessment_Survey.pdf)
- [Choices for Care Alignment Report FINAL \(/sites/asd/files/documents/HCBS_Alignment_Report_Choices_for_Care.pdf\)](/sites/asd/files/documents/HCBS_Alignment_Report_Choices_for_Care.pdf)
- [Choices for Care HCBS Reference Table - Home-Based \(/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf\)](/sites/asd/files/documents/Regulations_Table_for_AFC_AD_CM.pdf)
- [Choices for Care Reference Table - Enhanced Residential Care \(/sites/asd/files/documents/Regulations_Table_for_ERC.pdf\)](/sites/asd/files/documents/Regulations_Table_for_ERC.pdf)
- [Choices for Care Work Plan \(updated December 2016\) \(/sites/asd/files/documents/Choices_for_Care_HCBS_Work_Plan_Revised_December_2016.pdf\)](/sites/asd/files/documents/Choices_for_Care_HCBS_Work_Plan_Revised_December_2016.pdf)
 - [DRAFT Case Management Standards Revision \(/sites/asd/files/documents/DRAFT_Case_Management_Standards.pdf\)](/sites/asd/files/documents/DRAFT_Case_Management_Standards.pdf)
 - [DRAFT List of Case Management Standards Changes \(/sites/asd/files/documents/Case%20Management%20Standards%20List%20of%20Changes.pdf\)](/sites/asd/files/documents/Case%20Management%20Standards%20List%20of%20Changes.pdf)
 - [DRAFT Adult Day Standards Revision \(/sites/asd/files/documents/DRAFT_Adult_Day_Standards.pdf\)](/sites/asd/files/documents/DRAFT_Adult_Day_Standards.pdf)
 - [DRAFT List of Adult Day Standards Changes \(/sites/asd/files/documents/Adult%20Day%20Standards%20List%20of%20Changes.pdf\)](/sites/asd/files/documents/Adult%20Day%20Standards%20List%20of%20Changes.pdf)
 - [DRAFT Universal Provider Standards Manual Section \(/sites/asd/files/documents/DRAFT%20Universal%20Provider%20Standards%20Manual%20Section.pdf\)](/sites/asd/files/documents/DRAFT%20Universal%20Provider%20Standards%20Manual%20Section.pdf)
 - [DRAFT Adult Family Care Manual Section \(/sites/asd/files/documents/CFC_Manual_Section_Adult_Family_Care_DRAFT.pdf\)](/sites/asd/files/documents/CFC_Manual_Section_Adult_Family_Care_DRAFT.pdf)
 - [DRAFT Rights & Responsibilities Manual Section \(/sites/asd/files/documents/CFC_Manual_Section_Rights%26Responsibilities_DRAFT.pdf\)](/sites/asd/files/documents/CFC_Manual_Section_Rights%26Responsibilities_DRAFT.pdf)
 - [DRAFT Live-In Care Agreement Form 808 \(/sites/asd/files/documents/CFC_LiveIn_Requirements%20808%20Form%20DRAFT.pdf\)](/sites/asd/files/documents/CFC_LiveIn_Requirements%20808%20Form%20DRAFT.pdf)
 - [FINAL Case Management Standards Revision \(http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf\)](http://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards_Jan_2017.pdf)
 - [FINAL Adult Day Standards Revision \(http://asd.vermont.gov/sites/asd/files/documents/Adult_Day_Standards_January_2017.pdf\)](http://asd.vermont.gov/sites/asd/files/documents/Adult_Day_Standards_January_2017.pdf)
- [TBI Program Alignment Report FINAL \(/sites/asd/files/documents/HCBS_Alignment_Report_TBI.pdf\)](/sites/asd/files/documents/HCBS_Alignment_Report_TBI.pdf)

- [TBI Program Reference Table \(/sites/asd/files/documents/TBI Reference Table HCBS Regs.pdf\)](/sites/asd/files/documents/TBI%20Reference%20Table%20HCBS%20Regs.pdf)
- [TBI Program Work Plan \(/sites/asd/files/documents/TBI HCBS Work Plan.pdf\)](/sites/asd/files/documents/TBI%20HCBS%20Work%20Plan.pdf)

TAGS:

[Human Rights \(/tags/human-rights\)](/tags/human-rights/) |

[Long Term Services and Supports \(/tags/long-term-services-and-supports\)](/tags/long-term-services-and-supports/) |

[Medicaid \(/tags/medicaid\)](/tags/medicaid/) | [Standards \(/tags/standards\)](/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

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Kennedy, Alice

From: Lane, Sara
Sent: Tuesday, July 17, 2018 10:09 AM
To: Lane, Sara
Subject: FW: notes from HCBS consumer survey meeting
Attachments: Consumer Validation Survey Work Status.docx

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>

From: Tierney-Ward, Megan
Sent: Monday, November 20, 2017 3:33 PM
To: McMann, Angela <Angela.McMann@vermont.gov>; Courcelle, Andre <Andre.Courcelle@vermont.gov>; Senghas, Stuart <Stuart.Senghas@vermont.gov>; Lane, Sara <Sara.Lane@vermont.gov>
Subject: notes from HCBS consumer survey meeting

Attached are notes from today's meeting. I'm saving them in this folder:
I:\ALLDAIL\Global Commitment to Health\HCBS Rules Implementation\Consumer Validation Survey

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.

10 TIPS FOR FAMILY CAREGIVERS



Seek support from other caregivers. You are not alone!



Take care of your own health so that you can be strong enough to take care of your loved one.



Accept offers of help and suggest specific things people can do to help you.



Learn how to communicate effectively with doctors.

1



Be open to new technologies that can help you care for your loved one.

2



Watch out for signs of depression and don't delay getting professional help when you need it.

3



Caregiving is hard work so take respite breaks often.

4

7



Organize medical information so it's up to date and easy to find.

6



Make sure legal documents are in order.

5



Give yourself credit for doing the best you can in one of the toughest jobs there is!

8

9

10



CaregiverAction.org

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.

First Name	Last Name	Email	Provider Name	HCBS Service
			Bennington Project Independence	Adult Day
			CarePartners Adult Day Services	Adult Day
			Elderly Services, Inc.	Adult Day
			Gilford Medical Center Adult Day Center	Adult Day
			Green Mountain Adult Day Services of Orleans County	Adult Day
			Interage Adult Day Services	Adult Day
			Lamoille Day Health Services	Adult Day
			Oxbow Senior Independence Program	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 Services	Adult Family Care
			Upper Valley Services	Adult Family Care
			Choice TBI Support Services, Inc.	Adult Family Care
			Counseling Services of Addison County	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, Inc.	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 Aging	Case Management
			Addison County Home Health and Hospice	Case Management
			Central VT Home Health and Hospice	Case Management
			Franklin County Home Health Agency	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

First Name	Last Name	Email	Provider Name	HCBS Service
			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

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Friday, November 17, 2017 10:00 AM
To: Suzanne Santarcangelo (ssantarcangelo@phpg.com); Tierney-Ward, Megan; Courcelle, Andre
Subject: CMS CQS Question due Today
Attachments: TBI HCBS Final Alignment Report 11.21.16.docx

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

State of Vermont
Comprehensive Quality Strategy Systemic Assessment

Section III State Standards:
Home and Community Based Services

Specialized Health Population:
Traumatic Brain Injury Services
Global Commitment to Health Managed Care

February 2016; 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. Thus, 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.

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 services 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 (CQS) will review the rules and guidance supporting all Special Health Need Populations served under the Demonstration. The goal of these efforts is to promote enhanced quality in all services provided in community settings authorized under the State Plan and the Global Commitment Demonstration. This report focuses on the Traumatic Brain Injury (TBI) Services.

Eligibility and Enrollment

Persons may become eligible for participation in the TBI program by meeting traditional Medicaid eligibility rules or long term care eligibility rules, which include HCBS institutional eligibility rules and by also meeting TBI program criteria for enrollment as defined by the Department for Aging and Independent Living. Approximately, 50% of TBI program expenditures for persons whose eligibility is based on HCBS eligibility rules.

Traumatic Brain Injury Services

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 are provided to individuals, as appropriate, in accordance with an individual planning process that results in an 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 one or two persons in a home setting 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.

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.

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.

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 approved by the TBI program to accept participants needing recovery or long term support.

Table 1 below provides an overview of the residential arrangements in the TBI program.

Table 1. TBI Residential Settings

Residential Type	Who controls/owns setting	Regulatory Framework
Supervised Living (1-2 person)	Participant, family or TBI Provider Agency	<ul style="list-style-type: none"> • TBI Provider Manual & Agreement • Administrative Rules on Agency Designation
Shared Living (1-2 person)	Contracted Home Provider	<ul style="list-style-type: none"> • TBI Provider Manual & Agreement • Administrative Rules on Agency Designation
Staffed Living (1-2 person)	Participant, family or Provider	<ul style="list-style-type: none"> • TBI Provider Manual & Agreement • Administrative Rules on Agency Designation
Residential Treatment Facility (3 or more persons)	Provider	<ul style="list-style-type: none"> • TBI Provider Manual & Agreement • Residential Care Home Licensing Standards Level III or IV • Therapeutic Community Residence Licensing Standards

Recovery supports to assist with reentry into the workforce and community are offered to participants in everyday community settings where the participant lives, works and recreates. The TBI Program does not support sheltered workshops or disability-specific day treatment centers. TBI program benefits are outlined in Table 2 on the following page.

Table 2. TBI Program Benefits

42 CFR 440.180 HCBS Service	Vermont TBI Benefit Name	Is the Benefit Currently Available In the VT State Plan as a rehabilitative, institutional or other non-HCBS service?
Case Management	Case Management	No
Habilitation	Community Supports (in home, group home or other residence) – Skill acquisition, retention and improvement	Yes (PNMI) Yes (Specialized Rehabilitation Services)
Respite	Respite (in home or Nursing Facility)	No
Other Cost Effective Alternatives	Crisis Supports	Yes
	Environmental and Assisted technology; (home modification, devices and services)	In part as DME
	Psychology & Counseling Supports	Yes
Expanded Habilitation (Supported Employment)	Supported Employment	No

Vermont Policy Overview

The TBI program is staffed by 1 FTE at the State who is responsible for determining program eligibility and enrolment, approving providers, reviewing and approving all plans of care. State staff participates in program certification and with individualized rehabilitation and recovery teams. The following documents were reviewed as part of this policy analysis:

- DAIL Residential Care Home Licensing Regulations (October 3, 2000)
<http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/rch-licensing-regulations>
- Administrative Rules on Agency Designation (June 2003)
http://mentalhealth.vermont.gov/sites/dmh/files/policies/ADMINISTRATIVE_RULES_AGENCY_DESIGNATION_2003.pdf
- Licensing and Operating Regulations for Therapeutic Community Residences (January 2014)
<http://www.dlp.vermont.gov/regs/adopted-rule-with-effective-date-01-06-14.pdf>
- TBI Provider Manual <http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/tbi-provider-manual-1>
- TBI Application Package Guidelines and Forms <http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/tbi-application-package>
- TBI Sample Provider Agreement (available upon request from DAIL, Adult Services Division, 280 State Drive, HC2 South Waterbury VT 05671-2070)
- TBI Care Conference Minutes Form
<http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/section-vii>
- TBI Case Management Reporting Form
<http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/section-vii>
- TBI Independent Living Assessment Form
<http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/tbi-application-package>
- TBI Individual Service Plan Form
<http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/section-vi>
- TBI Life Skills Aide Report Form

- <http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/section-vii>
TBI Life Skill Aide Report Weekly Form
- <http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/section-vii>
TBI Quarterly Report Form
- <http://www.ddas.vermont.gov/ddas-policies/policies-tbi/policies-tbi-documents/section-vi>

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.

A summary of findings is provided below.

The TBI program is focused on medical rehabilitation and recovery. Guidelines, assessments and forms supporting the TBI program focus on skill building in areas such as speech, communication, cognitive skills, daily living skills, employment, mobility and progress towards rehabilitative goals. Documents used to approve program eligibility for the TBI program clearly indicate that the consumer has choices in where to receive services and program staff provides the individual with a list of recommended providers based on their medical/recovery profile. The consumer information package further encourages an in-person interview and outlines items for the consumer to consider in interviewing and choosing a provider. Additionally, various case planning forms and meeting note formats indicate that state has as expectation consumer involvement in all processes. Meeting notes require that a consumer documents their approval with a signature. Processes are required to be person centered. However, written guidance that explicitly outlines elements of person centered planning, beyond functional assessments and rehabilitative goals do not currently exist. There are no statements of participant's rights, sample chart audit tools, or sample agreements that provide examples of best practice in person-centered planning as contemplated in the federal HCBS rule. Along these lines, standards for service and provider agreements do not differ between the rehabilitation program and the long-term services and support program. Standards that outline expectations for transitional planning and continuity of care are not documented. Setting characteristics are guided by licensing and provider approval processes.

Summary and Options for Next Steps

Currently, the TBI program is overseen by one FTE State staff that is responsible for all aspects of approval, care planning and auditing. No specific staff manual or survey tools exist for audits and provider oversight. Provider reporting is focused progress on rehabilitation plan goals and objectives and updates in functional assessments specific to each individual participant. Provider reporting does not include written documentation of all aspects of person-centered planning and enrollee decision making as defined in federal HCBS rules.

The State could consider merging the TBI program with the Choices for Care program. Standards and quality oversight relevant to both populations (e.g., conflict of interest, person centered planning,

case management, universal provider standards, quality reviews) could be unified, while specialty specific guidelines (e.g., enrollee eligibility, staff training, provider certifications, etc.) for persons with TBI could be maintained. Alternatively, the State could maintain separate operational structures and adopt written documentation and audit tools that support the highly unique nature of TBI recovery and rehabilitative settings on balance with those persons who may need long term services and supports in a setting outside of their home.

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	<ul style="list-style-type: none"> Regulations define State expectations for all settings regardless of type Licensing reapplications are required annually Revisions may also impact providers not involved with the TBI 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
Merge program requirements with Choices for Care program standards, using relevant oversight standards and tools for program oversight while maintaining TBI specific expertise and protocols.	<ul style="list-style-type: none"> TBI audits may require more resources if content is expanded TBI Training requirements may need to be enhanced to include enhanced standards
Enhance current TBI provider standards to include more specific data reporting requirements; data that illustrates provider adherence to HCBS and VT regulations	<ul style="list-style-type: none"> Standards could include examples that align with federal language in addition to those Vermont specific protections Providers could engage in data reporting on targeted HCBS characteristics through quarterly and annual reporting
Conduct periodic consumer and stakeholder surveys to assess provider adherence to specific standards	<ul style="list-style-type: none"> Consumer self-report could allow for more direct and targeted quality improvement Stakeholders could include family members, legal guardian, and ombudsmen reports
Create written audit and provider approval guidelines that include details regarding person-centered planning and HCBS settings characteristics	<ul style="list-style-type: none"> Audits may require more resources if content is expanded
Include enhanced data collection in the new HSE/MMIS IT structure, especially as it relates to collecting care plan and settings information	<ul style="list-style-type: none"> Current AHS plans to update its IT structure provide an opportunity for TBI to define information needed to augment current provider performance and quality monitoring

Preliminary List of Options for Quality Assessment and Improvement	
Potential Next Steps	Considerations
<p>Update or create tools and guidance that support desired characteristics such as:</p> <ul style="list-style-type: none"> • Sample supervised or group living agreements; participant rights statements • Create participant handbooks that remind enrollees of their rights • Add prompts and instructions to the ILA and Care Plan reporting forms that specifically remind people to ask about and document decisions regarding door locks, room décor, access to food, and other accommodations outlined in the federal rule 	<ul style="list-style-type: none"> • Revising current materials would provide ongoing access to clear examples of State expectations

Appendix A: HCBS Settings Requirements and Vermont Regulation and Policy Crosswalk

HCBS Settings Requirements: VT Policy Assessment				
42 CFR HCBS Requirement HCBS	Setting Requirements	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	1. <u>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	TBI Provider Manual Sec I, Sec III, Sec. V TBI Application Release & Consent Residential Care Home Licensing Regulations Sec. 6	<ul style="list-style-type: none">• TBI application materials and provider manual provide that persons receive services in settings of their choice, commensurate with their abilities and person-centered plans.• ILA guidelines require planning, goals and objectives that support the recipient recovering skills needed to engage in their everyday community life and routines. Planning is based on functional assessments, personal choice in settings and reflect a person's medical needs, abilities, and preferences.• VT does not fund segregated work environments.• Community supports are individualized and not center based.• The Residents' Rights section of the Residential Care Home Licensing Standards includes an emphasis on individuality and community participation.	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. The setting options are identified, 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		<ul style="list-style-type: none">• TBI guidelines provide that persons receive information on all options available to support community living.• The participants make the final decision on where and how to receive recovery services.• Residential Care Home regulations require room and board agreements.• Agencies are expected to be community providers with a specialized rehabilitation services specific to TBI recovery.• For out of home settings, room and board is expected to be paid by the recipient.	Alignment
	3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint		<ul style="list-style-type: none">• Regulations require processes to prevent and address abuse, neglect, and exploitation.• Supervised living arrangements are supported through Designated and Specialized Agencies	Alignment
Policy Alignment		Residential Care	Community Living	Residential Care

HCBS Settings Requirements: VT Policy Assessment					
42 CFR HCBS Requirement	Setting Requirements	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Community Living	Residential Care
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	Therapeutic Community Residence Licensing Regulations Sec. 5.5, 5.17, VI	TBI Provider Manual Sec I, Sec III, Sec IV Residential Care Home Licensing Regulations Sec. 1.1; 5.5(b); 5.10 (e) (2) Sec. 6. Therapeutic Community Residence Licensing Regulations Sec. 5.5, 5.6, 5.17, VI	<ul style="list-style-type: none">• TBI rehabilitation program is designed to support recovery and skill building based on a person's daily routine, social, recreational and work environments.• 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.• 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.• Participants have the right to refuse any services or activities offered, to administer their own medications when they possess the desire and capability• Therapeutic Community Residence are transitional in nature and provide all-inclusive services with the primary goal of stabilizing crisis and providing life skills training and other recovery services needed to assist in community re-entry.	Alignment	Alignment
5. Facilitates individual choice regarding services and supports, <u>and who provides them</u>		TBI Provider Manual Sec I, Sec III, TBI Application Release & Consent Agency Designation: Sec 4.13	<ul style="list-style-type: none">• All participants choose where and how to receive their TBI services and supports.• Participants who require a supervised living arrangement receive case management from a host agency. The host agency is responsible for creating the rehabilitation plan and providing life skills aides and other services (e.g. OT/PT/SLP) as needed. The host agency is responsible for oversight of the home provider and the care plan and following up on any client concerns with the home, plan, or other services.	Alignment	Alignment

HCBS Settings Requirements: VT Policy Assessment				Policy Alignment	
42 CFR HCBS Requirement	Setting Requirements	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Silent (Shared living agreement standards do not exist)	Alignment
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.	Residential Care Home Licensing Regulations Sec. 4.3 (b), (d), (e) Sec. 5.2 (a-d), 5.3 (a), (e- h) Sec. 6.14 MCO Grievance and Appeal Rules Therapeutic Community Residence Licensing Regulations Sec 5.2, 5.4,	<ul style="list-style-type: none">• Residential Care Home 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).• Model agreements or guidelines do not currently exist for community living arrangements• TCR regulations require written admission agreements and that outline services to be provided, rate to be charged, and all other financial issues including discharge and transfer status and financial implications. Treatment facilities are anticipated to be transitional in nature based on the individual treatment plan goals and objectives. TCR's must give participants 30-day written notice of any change in rates or services. Discharges are individually planned based on treatment plan goals and participant needs.	Alignment	Alignment
7. Each individual has privacy in their sleeping or living unit	TBI Provider Manual Residential Care Home Licensing Regulations Sec. X. 9.2(e-g) Therapeutic Community Residence Licensing Regulations Sec. 9.1	<ul style="list-style-type: none">• Supervised living arrangements are expected to include private rooms, unless the participant agrees otherwise.• Residential Care Home and TCR 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 the assigned resident (s).	Alignment	Alignment	Alignment

HCBS Settings Requirements: VT Policy Assessment				Policy Alignment	
42 CFR HCBS Requirement	TCB Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Community Living	Residential Care	
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	Residential Care Home Licensing Regulations Sec. IX Therapeutic Community Residence Licensing Regulations Sec. 9.1	<ul style="list-style-type: none">• TBI guidance for out of home settings does not indicate who has keys.• Residential Care Home and TCR Licensing standards do not specify lockable units.	Silent	Silent	
9. Individuals sharing units have a choice of roommates in that setting	TBI Provider Manual Sec V.	<ul style="list-style-type: none">• Provider Manual states that participants are expected to have private rooms unless the participant agrees otherwise.• Participants review and interview all persons in potential setting prior to deciding on final option.	Alignment	Alignment	
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	TBI Provider Manual Sec V Residential Care Home Licensing Regulations Sec. IX	<ul style="list-style-type: none">• Guidelines do not specify decor standards• Residential Care Level III and TCR licensing standards do not specify standards for room décor	Silent	Silent	
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	TBI Provider Manual Sec I, Sec III, Sec. IV, VII Residential Care Home Licensing Regulations Sec. 7.1 (c)(4) Therapeutic Community Residence Licensing Regulations Sec. 5.5, 5.7, 6.17, 6.20, 7.1	<ul style="list-style-type: none">• TBI rehabilitation program is designed to support recovery and skill building based on a person's daily routine, social, recreational and work environments.• TBI program standards require that participants are actively engage in outlining their schedule and daily routines weekly.• Residential Care Level III licensing standards provide for alternative meals on request but do not specify 24/7 access to food.• Residential Care Home Regulations provide that facilities that do offer common kitchens must make them available for participant use at all times.• TCR standards provide that participants have responsibility for themselves and in deciding what activities and/or daily schedules to engage in during their stay.• TCR's must provide alternative meal options upon request.• Residential Care Homes and TCR's must provide for private communications and allow visitors at least from 8 am to 8 pm or	Partial Standards are silent on 24/7 access to food.	Partial Residential Care Homes offer meal plans and are required make options available as requested by participants. Regulations are silent on 24/7 access	
12. Individuals are able to have visitors of their choosing <i>at any time</i>	Residential Care Home Licensing Regulations		Silent	Partial	

HCBS Settings Requirements: VT Policy Assessment				
42 CFR HCBS Requirement	Setting Requirements	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Community Living
13. The setting is physically accessible to the individual	DALI Housing Safety and Review Process Residential Care Home Licensing Regulations Sec. 9.5 Administrative Rules on Agency Designation Sec. 4.12 Therapeutic Community Residence Licensing Regulations Sec. 9.5	Therapeutic Community Residence Licensing Regulations Sec 6.5	<ul style="list-style-type: none">• longer, and residents may make other arrangements with the home for visitors; residents can refuse any visitor.• TBI rehabilitation program is designed to support recovery and skill building based on a person's daily routine, social, recreational and work environments.• TCR's cannot restrict a person's choices in visitors unless restrictions are court ordered.• TBI Long Term Care Services and Support Program does not include specific standards for persons who cannot return to their daily routine or family living	Alignment
14. Modification to HCBS Settings Requirements Restrictions of rights and/or restrictive practices are not contemplated in program guidance	13. The setting is physically accessible to the individual	<ul style="list-style-type: none">• Safety and Accessibility inspections are required of all settings. In addition, the DD Act also requires geographic accessibility of services.	Alignment	Alignment
(a) Identify a specific and individualized assessed need for modification		<ul style="list-style-type: none">• Restriction of rights and/or restrictive procedures are not contemplated in the TBI program• Changes in setting, diet, or activity plans in licensed residential care home are made with the input of the physician, participant and legal guardian, and/or team members of the participants choosing.	Silent	Silent
(b) Document the positive interventions and supports used prior			<ul style="list-style-type: none">• Rehabilitation plans are focused in skill building and recovery.	Silent
Policy Alignment				
Residential Care Home	Licensing regulations	outline minimum standards (e.g., 8 am to 8 pm) not maximum	Residential Care	Residential Care

HCBS Settings Requirements: VT Policy Assessment				Policy Alignment	
42 CFR HCBS Requirement	Setting Requirements	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Community Living	Residential Care
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		<ul style="list-style-type: none">• Participants in residential care settings are not presumed to meet nursing home level of care, thus no request for variance or additional information is required under regulation for this target group.	Silent	
(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		<ul style="list-style-type: none">• Restriction of rights and/or restrictive procedures are not contemplated in the TBI program	Silent	Silent
(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	Therapeutic Community Residence Licensing Regulations Sec. 3.2, 5.2	<ul style="list-style-type: none">• Restriction of rights and/or restrictive procedures are not contemplated in the TBI program• Restrictions of Rights are not allowed in TCR settings without the consent of the individual as part of a participant as part of the admission and/or treatment plan process.	Silent	Silent
(h) Include an assurance that interventions and supports will cause no harm to the individual			<ul style="list-style-type: none">• Restriction of rights and/or restrictive procedures are not contemplated in the TBI program	Silent	Silent

Appendix B: Person Centered Planning Requirements and Vermont Regulation and Policy Crosswalk

Person-Centered Planning Process Requirements: VT Policy Assessment					
42 CFR HCBS Requirement - Person Centered Process	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Community Living	Residential Care	Partial
1. Includes people chosen by the individual and led by person or legal rep where possible	Administrative Rules on Agency Designation Sec 4.9; 4.13 Therapeutic Community Residence Licensing Regulations Sec. 5.7	<ul style="list-style-type: none">• TBI manual and forms indicated that the consumer is involved in all aspects of planning commensurate with their medical profile and abilities; no specific guidelines exists related to choice of team members• For host agencies that are also Designated and Specialized Service Agencies under administrative rule all planning must include the consumer and include persons of their choosing.• TCR Standards provide that the person and any identified support people are involved in planning.	Guidance for Non-DA/SSA programs is missing	Guidance for Non-DA/SSA programs is missing	Partial
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	Administrative Rules on Agency Designation Sec 4.9; 4.13 Therapeutic Community Residence Licensing Regulations Sec 5.2, 5.5, VI	<ul style="list-style-type: none">• For host agencies that are also Designated and Specialized Service Agencies under the administrative rule all planning must involve and support informed decision making by the consumer and include persons of their choosing.• TCR standards require informed consent and decision making.	Guidance for Non-DA/SSA programs is missing	Guidance for Non-DA/SSA programs is missing	Partial
3. Is timely, occurs at times and locations of convenience to the individual	TBI Provider Manual Sec III, Sec V.	<ul style="list-style-type: none">• TBI I/LA and Care planning indicate that the recipient must be involved, but is silent on location and times• TBI program oversight includes attention to these details, however guidance is not written.	Silent	Silent	Alignment
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	Administrative Rules on Agency Designation Sec 4.9 AHS Policy on Limited English Proficiency Therapeutic Community Residence Licensing Regulations Sec VI	<ul style="list-style-type: none">• For host agencies that are also Designated and Specialized Service Agencies under the administrative rule all planning must involve and support informed decision making by the consumer and include persons of their choosing.• All units of government within the Agency of Human Services and contractors 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.• TBI manual requires that providers will develop processes and policies to handle complaints	Alignment	Alignment	Partial
5. Includes strategies for solving conflict or disagreement within the	TBI Provider Manual Sec III, Sec IV,		Conflict of interest policies	Conflict of interest	Partial

Person-Centered Planning Process Requirements: VT Policy Assessment				Policy Alignment	
42 CFR HCBS Requirement - Person Centered Process	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	<ul style="list-style-type: none">• TBI provider agreement requires that agencies provide information and access to ombudsman services when needed and/or requested• The TBI grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration. All TCR's must provide written information and access to health care ombudsmen and protection and advocacy groups such as the mental health law project.	Community Living	strengthened due to the all-inclusive nature of these services.
	MCO Grievance and Appeal Rules Residential Care Home Licensing Regulations Sec V 5.19, VI, XI Therapeutic Community Residence Licensing Regulations Sec 5.2	<ul style="list-style-type: none">• Participants choosing supervised living receive case management from a host agency. The host agency is responsible for facilitating an acceptable match of supervised living setting, contracting with the home provider on the participant's behalf, and developing the rehabilitation plan. 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.• The TBI 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.• Community Living providers cannot serve as case managers.	Partial	Conflict of interest policies	Partial Conflict of interest standards could be strengthened due to the all-inclusive nature of these services.
MCO Grievance and Appeal Agency Designation Sec. 4.15 Administrative Rules on			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, <i>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.</i> In these cases, the State must <i>devise protections including separation of entity and provider functions within provider entities,</i> which must be approved by CMS. Individuals must be provided with a <i>clear and accessible</i>	MCO Grievance and Appeal Rules	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, <i>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.</i> In these cases, the State must <i>devise protections including separation of entity and provider functions within provider entities,</i> which must be approved by CMS. Individuals must be provided with a <i>clear and accessible</i>

Person-Centered Planning Process Requirements: VT Policy Assessment				Policy Alignment	
42 CFR HCBS Requirement - Person Centered Process	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance		Community Living	Residential Care
	TBI Provider Manual Sec III; TBI Application Agency Designation Sec 4.9; 4.13; 4.14	<ul style="list-style-type: none">• TBI participants chose where to receive based on their medical profile and rehabilitation needs• Choice and consumer participation in the person-centered planning process is required for Designated and Specialized Service agencies.	Alignment	Alignment	Alignment
	8. Includes a method for the individual to request updates to the plan as needed	<ul style="list-style-type: none">• Plans must update every six months and reviewed quarterly in the rehabilitation program and annually in the long-term services and support program.• Active involvement of the participant in monthly meetings is expected. Monthly meetings include review of plans and any request for updates.	Alignment	Alignment	Partial Monthly meeting expectations could be stronger
	TBI Provider Manual Sec II, III TBI Application	<ul style="list-style-type: none">• Recommended settings provided to the participant in writing as part of the planning process	Alignment	Alignment	Alignment
	TBI Provider Manual Sec II, III TBI Application	<ul style="list-style-type: none">• Participants make final choice of settings as documented in the application and care planning process.	Alignment	Alignment	Alignment
	Administrative Rules on Agency Designation Sec 4.9; 4.13; 4.14 TBI Provider Manual Sec II, III TBI Application	<ul style="list-style-type: none">• Regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making.• Application and assessment guidelines support documentation of all strengths and needs.	Alignment	Alignment	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment		Policy Alignment	
42 CFR HCBS Requirement - Person Centered Process	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Alignment
	TBI Provider Manual Sec II, III	• TBI guidelines provide for service and person-centered plans to be based on functional assessments, strengths, preferences, and supports that maximize independence.	Alignment
	TBI Application	• Guidelines provide for service and person-centered plans to be based on functional assessments, strengths, preferences, and supports that maximize independence.	Alignment
	TBI Provider Manual Sec II, III	• TBI care plans support the identification of individually identified goals and desired outcomes.	Alignment
	TBI Application	• TBI guidelines call for plans to reflect all goals, actions steps, persons responsible (paid and unpaid), and target dates.	Alignment
	TBI Provider Manual Sec II, III	• TBI guidelines call for plans to reflect all goals, actions steps, persons responsible (paid and unpaid), and target dates.	Alignment
12. Reflect needs identified through functional assessments			Alignment
13. Include individually identified goals and desired outcomes			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			Alignment
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.	Silent
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)		• For Designated and Specialized Agency programs, administrative rules require plans be written in plain English and are accessible based the unique needs and abilities of the consumer. • 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
AHS Limited English Proficiency Policy			Alignment
Administrative Rules on Agency Designation			Alignment
Sec 4.9 Therapeutic Community Residence Licensing Regulations Sec. 6.26, 6.27			Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment					Policy Alignment	
42 CFR HCBS Requirement - Person Centered Process	TBI Policy, Rules, Guidelines	VT Statutory or Policy Guidance	Alignment	Community Living	Residential Care	
	TBI Provider Manual Sec V	<ul style="list-style-type: none">The TBI case management standards require the case manager to monitor all plan activities and progress.	Alignment	Alignment	Alignment	
	TBI Provider Manual Sec II, III	<ul style="list-style-type: none">All plans require participant and/or guardian agreement prior to implementation.	Alignment	Alignment	Alignment	
	TBI Provider Manual Sec II, III	<ul style="list-style-type: none">Guidelines indicate plans should be kept on file, but are silent on how copies are distributed	Silent	Silent	Silent	
	N/A	<ul style="list-style-type: none">Self-direction is not an option in the TBI program	N/A	N/A	N/A	
	TBI Provider Manual Sec IV, V	<ul style="list-style-type: none">Funding decisions and final approval by TBI State staff include a review to ensure services are coordinated and responsive to the individual's needs and are not duplicative or unnecessary.All TBI services require prior authorization	Alignment	Alignment	Alignment	
	Residential Care Home Licensing Regulations Sec. 5.7, 5.9(c)	<ul style="list-style-type: none">TBI guidelines require reviews quarterly in the in the rehabilitation program and annually in the long-term service and supports program.Active involvement of the participant in monthly meetings is expected. Monthly meetings include review of plans and any request for updates.	Partial	Partial	Partial	
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			Partial	Monthly meeting expectations could be stronger	Partial	
21. Prevent the provision of unnecessary or inappropriate services and supports			Alignment	Alignment	Alignment	
20. Include those services, the purpose or control of which the individual elects to self-direct	N/A	<ul style="list-style-type: none">Self-direction is not an option in the TBI program	N/A	N/A	N/A	
19. Be distributed to the individual and other people involved in the plan	TBI Provider Manual Sec II, III	<ul style="list-style-type: none">Guidelines indicate plans should be kept on file, but are silent on how copies are distributed	Silent	Silent	Silent	
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	TBI Provider Manual Sec II, III Administrative Rules on Agency Designation Sec 4.9; 4.13; 4.14	<ul style="list-style-type: none">All plans require participant and/or guardian agreement prior to implementation.	Alignment	Alignment	Alignment	
17. Identify the individual and/or entity responsible for monitoring the plan	TBI Provider Manual Sec V	<ul style="list-style-type: none">The TBI case management standards require the case manager to monitor all plan activities and progress.	Alignment	Alignment	Alignment	

Kennedy, Alice

From: Skaflestad, Shawn
Sent: Monday, July 24, 2017 3:07 PM
To: Tierney-Ward, Megan; Courcelle, Andre; Gerstenberger, Roy; Harrigan, Emma; Omland, Laurel; Hill, Bard; Clark, Bill
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

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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MEDICAID COMPREHENSIVE QUALITY STRATEGY



**STATE OF VERMONT
AGENCY OF HUMAN SERVICES**

*Produced by
Members of the
AHS Performance Accountability Committee (PAC)
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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.

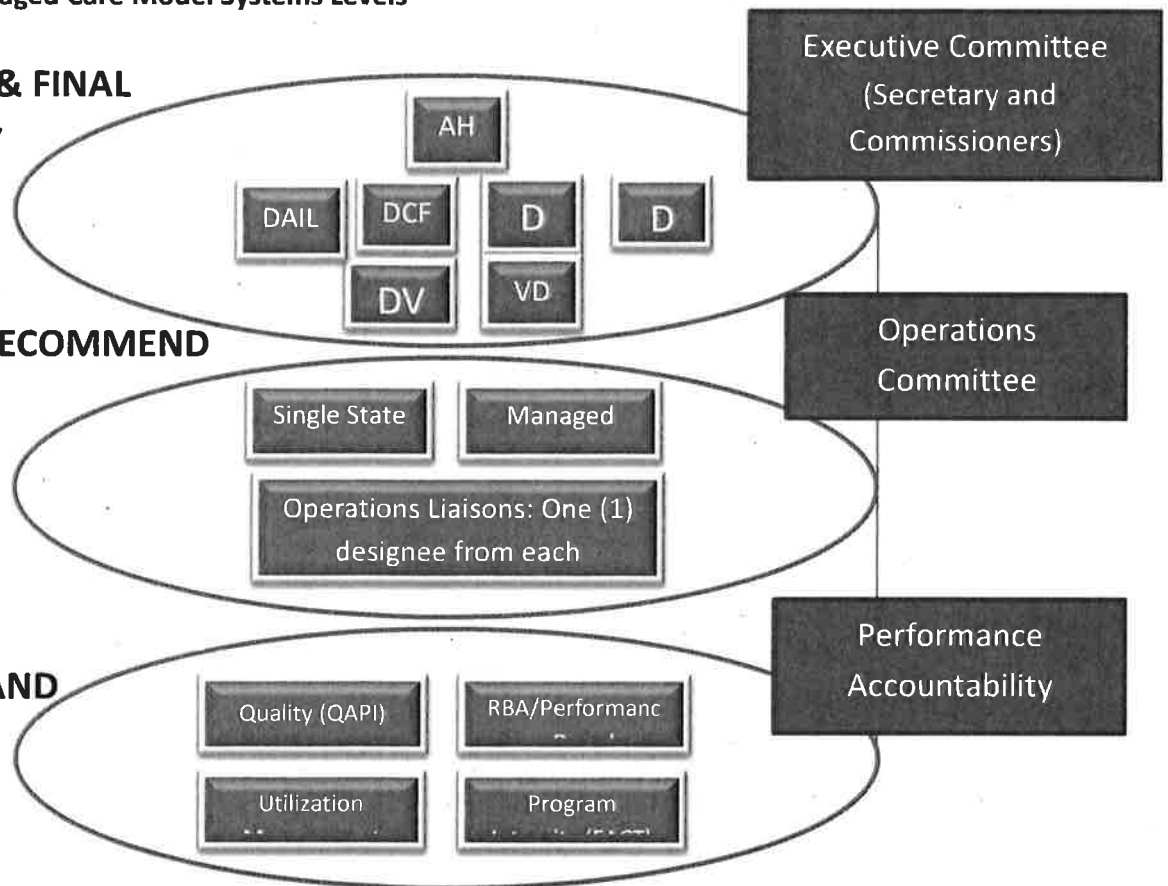
The need for AHS-wide cross-departmental teams has been identified for three core areas. These include Executive, Operations, and Performance Accountability. Each team is facilitated by an AHS senior staff member and/or senior managers from departments and divisions impacted by Global Commitment. These 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

PLANNING & FINAL AUTHORITY

ADVISE & RECOMMEND

MONITOR AND OVERSEE



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.

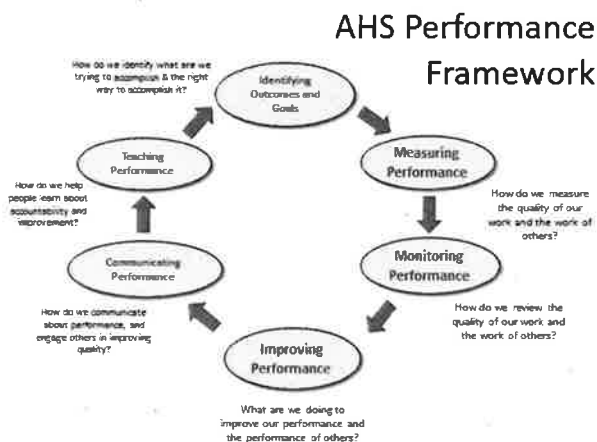
Chair: The Operations Committee chair shall appoint a Performance Accountability chair who will report the Committee's recommendations to the Operations Committee.

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 provide 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)	<i>Ambulatory Care</i>	TBD*	TBD*
Developmental Disability Services (DS)	<i>Ambulatory Care</i>	TBD*	TBD*
Traumatic Brain Injury (TBI)	<i>Ambulatory Care</i>	TBD*	TBD*
Community Rehabilitation and Treatment (CRT)	<i>Ambulatory Care</i>	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)	LTSS 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 Requirements

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 warehouse 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 its 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).

REGULATORY REQUIREMENT	EXAMPLES OF ACCEPTABLE PRACTICE
Daily activities	<p>Individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.</p> <p>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.</p> <p>The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.</p>
Physical environment With whom to interact	<p>The individual has his/her own bedroom or shares a room with a roommate of choice.</p> <p>The individual chooses with whom to eat or to eat alone.</p> <p>Visitors are not restricted.</p>
Choice of services	<p>Staff ask individual about needs and preferences. Individuals are aware of how to make a service request.</p> <p>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.</p>
Choice of providers	<p>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.</p>

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>.

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 Medcity 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. Dynasaur.

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
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.

Advanced Primary Care Practice/Patient Centered Medical Home

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.

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 §441.301(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.
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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
---	---

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 §441.301(c)(4)(ii).	
Table 9 fails to include "Examples of Best Practices" related to the aforementioned requirement.	

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>; 'Inuss@neweditions.net' <Inuss@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>; Inuss@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>; Inuss@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

VI	CMS Submission	Submit STP with Heightened Scrutiny information to CMS for review		1/17/2019
		<i>Anticipated CMS Approval</i>		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



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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.

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7500 Security Boulevard Baltimore, MD 21244

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

HCBS CQS July 2018 001335

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 <i>[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]</i>	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 <i>[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]</i>		Please complete	
Implementation of new rules and regulations: 100% complete <i>[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]</i>		Please complete	
Site-specific Assessments			

Completion of site-specific assessment <i>[The date when the overall completion of the site-specific assessment, including review of all settings and the validation of assessment results.]</i>	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 Please complete	HCBS DS Timeline
Submit final STP to CMS			
Site-specific Remediation¹ Completion of residential provider remediation: 25% <i>[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.]</i>	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 Please complete	HCBS DS Timeline
Completion of residential provider remediation: 50%			

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

<p>[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.]</p>			
<p>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.]</p>		Please complete	
<p>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.]</p>		Please complete	
<p>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.]</p>	<p>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.</p> <p>CFC, DS, and TBI</p> <p>SED and CRT</p>	<p>Completed (9/30/2016)</p> <p>9/30/2017</p>	<p>HCBS DS Timeline</p>

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 Scrutiny²			
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

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% <i>[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.]</i>		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	

<p><i>[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.]</i></p>		
<p>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%</p> <p><i>[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.]</i></p>	<p>Please complete</p>	
<p>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%</p> <p><i>[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.]</i></p>	<p>Please complete</p>	
<p>Complete beneficiary relocation across all providers: 25%</p>	<p>Identify VT plan to relocate consumers – if necessary. Currently</p>	<p>HCBS DS Timeline</p>

[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	

¹This section includes only those providers where remediation was required.

²The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

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.]			

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?

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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
<p>#1. <u>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</p>	<p>Rehabilitation services assume community living; guidelines are silent on TBI long term services and supports program</p>	<ul style="list-style-type: none"> 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.
<p>#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.</p> <p>(b) For settings in which landlord tenant laws do not apply, the State must ensure that a lease,</p>	<p>Silent - Shared living agreement standards do not exist.</p>	<ul style="list-style-type: none"> 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

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 <u>provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.</u>		self-assessment tools. l. DAIL to coordinate ASD quality activities with AHS and DVHA quality assurances under the Global Commitment Comprehensive Quality Plan (CQP).
#8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	Standards are silent.	m. DAIL to update TBI Provider Manual Sec. IV, V to include "Agreement for live in Care"
#10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.		n. DAIL to update TBI Provider manual Sec. IV, V, DAIL Home Safety and Accessibility Standards
#11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.		o. DAIL to update TBI Participant Rights & Responsibilities
#12. Individuals are able to have visitors of their choosing <u>at any time.</u>		
#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.

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
#3. Is timely, occurs at times and locations of convenience to the individual	Standards are silent. Documentation requirements must be strengthened.	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.
#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	i. DAIL to publish revised documents and distribute to stakeholders. p. DAIL to provide training and technical assistance to providers and stakeholders as needed.
#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, <u>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.</u> In these cases, the State must <u>devise conflict of interest protections including separation of entity and provider functions within provider entities</u> , which must be approved by CMS. Individuals must be provided with a <u>clear and accessible alternative dispute resolution process</u>		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
#8. Includes a method for the individual to request updates to the plan as needed	Monthly meeting expectations	

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
#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.	

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

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 <i>[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]</i>	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 <i>[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]</i>		Please complete	
Implementation of new rules and regulations: 100% complete <i>[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]</i>		Please complete	
Site-specific Assessments			

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 Please complete	HCBS DS Timeline
Submit final STP to CMS			
Site-specific Remediation¹ 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 Please complete	HCBS DS Timeline
Completion of residential provider remediation: 50%			

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.

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 Scrutiny² 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

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% <i>[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.]</i>		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	

<i>[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.]</i>			
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% <i>[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.]</i>	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% <i>[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.]</i>	Please complete		
Complete beneficiary relocation across all providers: 25%	Identify VT plan to relocate consumers – if necessary. Currently	Please complete	HCBS DS Timeline

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

¹This section includes only those providers where remediation was required.

²The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

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.]			

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



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-

CMCS Informational Bulletin – Page 2

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,

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
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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

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.
- 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.
- **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 CFR 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 CFR 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 an 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 individual’s 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 <i>[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]</i>	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 <i>[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]</i>		Please complete	
Implementation of new rules and regulations: 100% complete <i>[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]</i>		Please complete	
Site-specific Assessments			

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 Please complete	HCBS DS Timeline
Submit final STP to CMS			
Site-specific Remediation¹ 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 Please complete	HCBS DS Timeline
Completion of residential provider remediation: 50%			

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

<i>[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.]</i>				
Completion of residential provider remediation: 75% <i>[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.]</i>	Please complete			
Completion of residential provider remediation: 100% <i>[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.]</i>	Please complete			
Completion of nonresidential provider remediation: 25% <i>[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.]</i>		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.

Commented [MM3]:
Please provide a completion date.

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? 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

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% <i>[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.]</i>	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		

<i>[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.]</i>			
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% <i>[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.]</i>	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% <i>[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.]</i>	Please complete		
Complete beneficiary relocation across all providers: 25%	Identify VT plan to relocate consumers – if necessary. Currently	Please complete	HCBS DS Timeline

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

¹This section includes only those providers where remediation was required.

²The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

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.]			

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
 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).

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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<p>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.</p>	<p>the CQS. Each specialized program will address the conflict free case management element in its own HCBS Compliance Plan.</p> <p>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.</p>
<p>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)(I)(vi);</p>	
<p>2) The setting in which the individual resides is chosen by the individual. 42 CFR §441.301(c)(2)(i);</p>	
<p>3) Natural unpaid supports are provided voluntarily to the individual in lieu of ... HCBS waiver services and supports. 42 CFR §441.301(c)(2)(v).</p>	
<p>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.</p>	<p>Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.</p>

Ongoing Monitoring & Oversight

<p>Vermont programs that provide support, intervention, care for people with DD must have oversight</p>	<p>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.</p> <p>Under Vermont statute, the Department of Disabilities Aging and Independent Living provides oversight to Vermont programs that provide services to people with ID/DD.</p>
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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.	<p>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.</p> <p><u>Each specialized program including Developmental Disabilities will complete an assessment/review process in its own HCBS Compliance Plan.</u></p>
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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.	<p>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.</p> <p><u>Each specialized program including Developmental Disabilities will complete an assessment/review process in its own HCBS Compliance Plan</u></p>
--	--

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.	<u>Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.</u>
The CQS does not outline how you plan to ensure that the setting a person lives in is truly chosen by the person.	<u>Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.</u>
The CQS fails to outline how you will require service providers to foster the development of natural supports in a person's life.	<u>Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.</u>

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 §441.301(c)(4)(ii).	<u>Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.</u>
Table 9 fails to include "Examples of Best Practices" related to the aforementioned requirement.	<u>Each specialized program will address the person centered planning provisions and compliance steps in its own HCBS Compliance Plan.</u>

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.

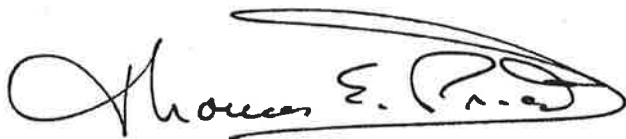
Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings.

Provide States with More Tools to Address the Opioid Epidemic

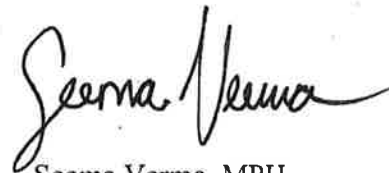
We are committed to ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities. In recognition of the urgent need to improve access to comprehensive substance abuse treatment, we will continue to work with states to improve care for 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 described 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

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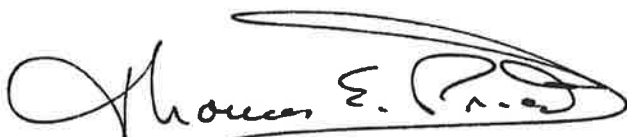
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We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our 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.

Service

service coordination

A01~ Service Planning and Coordination

Service Coordination: assistance to recipients in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Service Coordination responsibilities include, but are not limited to, developing, implementing and monitoring the ISA, coordinating medical and clinical services; establishing and maintaining a case record; reviewing and signing off on critical incident reports; and providing general oversight of services and supports. The provision of Service Coordination will be

B01~ Community Supports

B01 ~ Community Supports/Individual

Support: provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (two or more people). Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal home and community-based services rules.

B02~ Community Supports (GROUP)

C01~ Employment Assessment

C02~Employer and Job Dev.

C03~ Job Training

C04~ Ongoing Support

D01~ Respite Supports (by the hour)

D02~ Respite Supports (24 hr)

E01~Clinical Assessment

E02~ Individual Therapy

E03~ Family Therapy

E04~ Group Therapy

E05~Medication and Medical Support and Consultation

E08~ Other Clinical Services

**G01~ Emergency/Crisis Assessment,
Support, Referral**

G02~Emergency/Crisis Beds

H01~ Supervised Living

H02 ~ Staffed Living

H03 ~ Group Living

H04 ~ Shared Living (licensed)

H05 ~ Shared Living (not licensed)

**H06 ~ ICF/DD (Intermediate Care Facility for
people with Developmental Disabilities)**

I01 ~ Transportation Services

**E07 ~ Behavioral Support, Assessment,
Planning and Consultation Services**

N01 ~ Communication Support

N02 ~ Other Supportive Services

Agency Responses to Column B

On-call

Supervision of Staff and Homes

Service Coordination

Documentation/service notes

staffing provided at the hospital (services suspended)

Two or more staff performing A01 service- only one Coding Service

Consultation with other service coordinators

Crisis response

Home visits

attending appt with physician

phone contact with medical providers

hospital visits

coordination with clinical services

coordinate emergency respite/crisis support

Coordinate and information sharing regarding medication reviews and changes.

Supervision of staff working directly with an individual.

Monitoring the delivery of behavioral interventions and revising the plan as needed.

Being supervised when the supervision pertains to an individual recipient.

Interacting with outside organizations around an individual such as Courts, Police, Corrections, Social Security, Schools, Community Member, etc .

Provision of in-service training around the needs of an individual recipient.

Coordinating with a home provider about service needs, home visit schedules, etc.

Collaborating and information sharing with state Guardians

Providing the individual with essential transportation

Cross training with another Service Coordinator in order to provide backup services when primary service coordinator is not available.

Phone conversations pertaining to an individual recipient.

Visits to employment sites.

Records organization activities.

Resource development.

Coordination efforts to develop crisis support plans in response to challenging behaviors.

Case Management to consumers prior to their transfer date to our agency

All ISA related activity (Needs assessment, reviews, meetings, writups etc.)

Team meetings.

Attending IEP meetings

Completing and reviewing incident reports.

Meeting with/coordinating with family members of the individual.

Mental Health Court

Case Review for Clinical High Acuity Service Delivery; Clinical Review Committee meets to discuss cases with SC, (2) LICSW, (1) LCMHC, (1) CRC, (2) Senior specialists only SC bills times

General Paperwork such as timesheet approval

Safety Connections



HomeBase

VNA Adult day - Invoiced

Private Contracts

Cross training staff

Community: Client illness/vacation/no show

transportation without consumer

Think College

Coverage by Service Coord.

College Steps

Campus 26

SLP provides coverage if staff absent

Resource Center

Peer Advocacy Group Support; Paid Staff Peer Advocate and (2) Senior Staff Supports (1) Team
Leader On going resource and consultation supports

Onion River

SUCCEED

Project Search

Brightlight Adult Learning

Academy of Learning

BCBA Consultation Services

BCBA Consultation Services

Lifesteps center based supports

Community Supports provided to consumers prior to their transfer date for training purposes.

Contracted (Heartbeet, Latham)

Think College

VNA Adult day

Onion River

SUCCEED



Cross Training


Learning for Living Program

PAEA - Music/Art/Sensory

Planning, Prep, Cleanup

Cross Training, Staff Mentoring

Agency Managed Community Supports (1:2, 1:3)



Agency Employment Assessment

Agency Employment Annual Work Plan

Case managers capture this through MAPS process and activities delivered through A01

School Consultations

CWS Participation

Vocational Rehabilitation Partnerships

State Supported Employment Partnership

Job Development

Job Training

Think College

Staff Directed Support

Employer Check-ins

Agency Job Training

Ongoing Support

Employer Surveys

Self-managed Employment Supports

Contracted Voc Follow

Transportation Services to/from work

Employer Check-ins



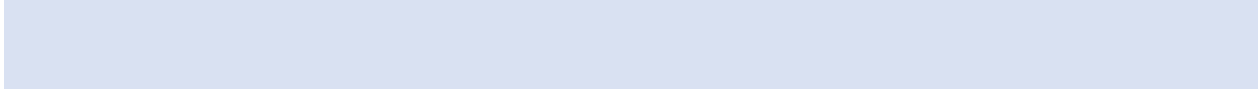
camps

Think College

Hospitalization-Suspending respite- 1.5 Time to staff

Respite: Variation between utilization and allocation of units


Overutilization of respite dollars when consumer ends services, transfers or moves to a new home. Dollars spent in advance of change



camps

Hospitalizations-Suspending Respite 1.5 Time to staff

Daily provided by employee of home provider or family



Nurse

Behaviorist

Psychiatrist

VCIN

Independent Living Assessment

Assessments by outside vendors


VCIN Level II assessment

SOTIPS/VOTIPS

Specialized Evaluations (Psychosexuals/Risk Assessments)

Functional Assessment

Behavioral Assessment/Consult



Therapy

Therapeutic horseback riding

Outside vendors who don't bill Medicaid

Massage Therapy

Functional Medicine - Assessments & Treatment

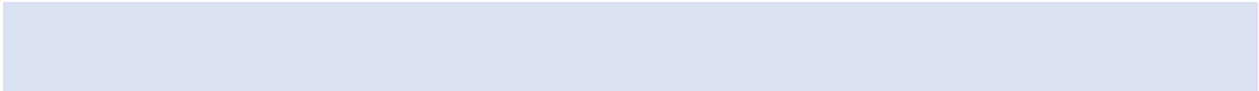
Acupuncture

Speech Language services

Movement Therapy

Sensory Diet OT

Equipment Maintenance, e.g., track system




Agency Clinical Services

Agency Individual Therapy

Physical Therapy

Personal Training for mobility maintenance




DBT

ART therapy

Circles

Sexuality

Agency Provided Group Therapy



Nursing oversight

Medication monitoring/Agency Psychiatrist

Med checks with contracted psychiatrist


Nursing consult and special care procedures

Coordination with primary and specialty medical providers

Contractor training

EFS creation and maintenance

Staff training



Facilitated communication

Adaptive horseback riding

Yoga

Needed Quarterly Team meetings with Therapist

PT, OT, Speech

Personal Training for mobility maintenance

Massage Therapy

Sensory Diet OT

Equipment Maintenance, e.g., track system

Assistive Technology




On-call Stipends/Pagers

VCIN

Crisis Coordinator/ Crisis Team

always identified these activities as A01. Exceptions would be Direct Support in responding to a Consumer who is actively in Crisis and needs either face-to face or phone support by crisis

We manage all of this through case managers and have always identified these activities as A01



Crisis house utilized for homeless clients

VCIN - Payments in excess of waiver spread

Crisis Bed for 1 individual at a time

Contracted Emergency/ Crisis Support

Individual Crisis



Crisis Housing

Crisis house/bed

Hourly home supports by staff

Staffed Supervised Living Direct Support

Contracted Worker Supervised Living Direct Support

Residential supports - assigned hours

Hourly home supports by employee of family member

n/a (billed under Community Supports)

24 hours staffed model for 2 individuals is 2 separate homes

Agency Managed Staffed Living

SUCCEED Staff Living

Out of State Residential

24 hour staffed model for 2 individuals in 1 home

Staffed Direct Support in individual's apartment 24/7

Pennington

Atwood

SUCCEED Residential

Hawk Lane

Farm House

East Terrace

1 foster child on DCF/Waiver

DCF Licensed, contracted SLP

Crisis Housing

Crisis house/bed

Shared living provider

Staffed Direct Support and Nursing 24/7 in home for 6 people

transportation Time & Miles with out consumers

mileage reimbursement

All employee mileage recorded on Agency expense sheet

Van costs in excess of Capped rate

Van payments and maintenance

Monthly payments for a handicap accessible van, to also inclde repair and maintenance

Community Support Staff mileage voucher

Accessible Van for multiple consumers

We provide vans and provide a reimbursemnt via a monthly payment.

Mileage

SSTA and Taxi

Accessible van for Individuals

Gas Cards


A solid light blue rectangular block used for redaction, positioned below the text 'Gas Cards'.

VCIN

Provide clinical consultation to treatment team members & individual in developing, monitoring, adjusting, and implementing positive behavioral supports targeting emotional regulation

We generally do not provide this with a behaviorist. We may have this done by a case manager and this would be coded as A01

Behavioral Support


A solid light blue rectangular block used for redaction, positioned below the text 'Behavioral Support'.

outside vendor

Sign language interpreters

Facilitated Communication

Contracted Speech and Language Consult

A solid light blue rectangular block used for redaction, positioned below the text 'Contracted Speech and Language Consult'.

Agency hired

Therapeutic horseback riding

DBT Skills Group

Relationships and Sexuality Group

Visions Group

Medicaid Allowable (Y/N)**SOCP Allowable (Y/N)**

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depends on length of stay

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unclear what this response means

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not sure what this response means

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y	y
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unclear what these stand for

y	y
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y	y
y	y
	Y
Y	Y
unsure	
unclear what this is	
N	?????
Y	Y
unsure	Unsure, possibly E07
unsure	possibly under E07
unsure	
Y	y
y	y
Y	???
Y	y

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Unsure what this is

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unclear what this is

? ?/E07?

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Y Y

y y

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unsure of the VCIN agreement/cant say unsure of the VCIN agreement/cant say

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Y Y

Y Y

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Meets this service definition

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N (employment service)

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? transportation included in rate?

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Should be E07

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should be E07

unsure

Y

E07?

y

y

direct billed to State Plan Medicaid??

E07???

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E07?

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E07?

E07?

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Y

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Should not be under A01

Should not be under A01

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unsure of the VCIN agreement/cant say

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under G02/G01??

under G02/G01??

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N. does not meet definition of community

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N. (Under G01/G02?)

N (Under G01/G02)

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N, not under A01

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y

HCBS Service or related activity not captured in current service codes (Responses to page 2)

Travel to meetings

Travel to coordinate with other supportive agencies

DSP travel in between direct care assignments

Meeting person

Gathering of documents Time spent working on intake and pre-admission

Coordination with DA for eligibility determination

Monthly core team at all regional schools

Family Information nights

Creation of needs assessment and funding proposal, present to Equity

Any contractual service done by outside vendors

Person transfers to CCS- Sending agency is still billing while we gather records, create team etc.

Consultation with peers

24 hour support done by individual provider

Funds allocated for van purchase and maintenance

Coordination with DA for eligibility determination

Mileage reimbursement

Groups that are offered with varying attendees

Record review (ISAs, Behavior Support Plan, etc.)

Supervision received

Training

Meetings

Billing entries

Payroll sheet

Person transfers to LSI

Home provider and Staff recruitment

Reference checking, background checks tracking

All indirect supervision

Scheduling

Employee Performance Evaluations

Service Coordinator Meeting

Senior Management Meeting

Employee supervision notes

Staff Attending Internal and external trainings

Therapeutic Options, CPR First Aid

Pre and In-service Training

General staff meeting

Team meetings

SLP contract meetings

Executive Advisor Meeting

Development, implementation and training of policies to match
State regulations

CWS and VR meetings

Equity and local funding committee

E H R committee

Employment Director's meeting

communication task force

Facilitating local self advocacy group, planning, coordination

Voices and Choices, other self advocacy efforts

Management of spreadsheet changes

Management of FEA budgets

Utilization review of services

Utilization review of respite funds

Consumer Wage reporting

Maintenance personnel contractual records

retention and destruction of records

Timesheet and expense reimbursement approval

Creation and adjustment of system

Ongoing training

Management of document library, scanning and uploading of data

Adding new staff and consumers to system, changing information

Mileage entries

Difference between 5% Admin rate for new/ transferred consumers and actual agency admin rate

Payment to Home Providers for 30 days after Death, move, transfer, end services, etc.

Staff out sick or vacations- Unable to provide services

Time spent traveling without consumer

Time spent developing and providing training

Planning events

Phone and email

no funding source

Services suspended because employer shuts down, but we still have all the costs with no revenue

Services suspended due to staff vacancy, but we still have program infrastructure expenses

Services suspended due to consumer vacation or illness, but we still have all the costs with no revenue

Overtime expenses, particularly in group home and staffed home situations due to vacancies or staff time off when canceling the

Consumer moves suddenly, owe 30 days to old provider while having to pay the new provider

Consumer dies, we pay provider 30 days

Consumer moves, dies or transfers and provider/family has used respite in excess of what agency was able to bill down.

GH vacancy over 90 days

Hospitalizations, Psychiatric Hospitalizations, Rehab

External Nurse Consultation

LIT

Children's group

E H R committee

Community Health Team

Employment Director's meeting

Managemnt of spreadsheet changes

Utilization review of services

Consumer Wage reporting

Maintenance personnel contractual records

Topical unscheduled information sharing

RN consultation with other staff

Electronic Record Training and form building

Relationship Developing

Crisis - 24 on call

Collaboration with Police

Social Security Documentation

Medication Delegation

1:1 consultation to teams

Client damages that occur in home and community settings

Crisis: Client needs to be in an unfunded crisis stabilization and we still need to maintain an SLP

Rep-Payee Service

Work for June Grads

Bridge Case Dispo

Any work done to support state work groups

CIR&Incident reports

Curriculum prep time (art/music therapy, sensory, communication planning)

Organizing and attending transitional fairs

Transitional employment assessments for those coming out of high school not yet in services

Disaster and Post-Ventilation Services

VCIN

Hospitalizations but still paying for services

Purchase orders

ISA Data from Home Providers

: 2016

Town	Home Health Agency	Area Agency on Aging
Addison	Addison County Home Health & Hospice	Age Well
Bridport	Addison County Home Health & Hospice	Age Well
Bristol	Addison County Home Health & Hospice	Age Well
Cornwall	Addison County Home Health & Hospice	Age Well
East Middlebury	Addison County Home Health & Hospice	Age Well
Ferrisburg	Addison County Home Health & Hospice	Age Well
Goshen	Addison County Home Health & Hospice	Age Well
Leicester	Addison County Home Health & Hospice	Age Well
Lincoln	Addison County Home Health & Hospice	Age Well
Middlebury	Addison County Home Health & Hospice	Age Well
Monkton	Addison County Home Health & Hospice	Age Well
New Haven	Addison County Home Health & Hospice	Age Well
North Ferrisburg	Addison County Home Health & Hospice	Age Well
Orwell	Addison County Home Health & Hospice	Age Well
Panton	Addison County Home Health & Hospice	Age Well
Ripton	Addison County Home Health & Hospice	Age Well
Salisbury	Addison County Home Health & Hospice	Age Well
Shoreham	Addison County Home Health & Hospice	Age Well
Starksboro	Addison County Home Health & Hospice	Age Well
Vergennes	Addison County Home Health & Hospice	Age Well
Waltham	Addison County Home Health & Hospice	Age Well
Weybridge	Addison County Home Health & Hospice	Age Well
Whiting	Addison County Home Health & Hospice	Age Well
East Granville	VNA of Vermont and New Hampshire	Central VT Council on Aging
Granville	VNA of Vermont and New Hampshire	Central VT Council on Aging
Hancock	VNA of Vermont and New Hampshire	Central VT Council on Aging
Arlington	Manchester Health Services	Southwestern VT Council on Aging
East Arlington	Manchester Health Services	Southwestern VT Council on Aging
Manchester	Manchester Health Services	Southwestern VT Council on Aging
Manchester Center	Manchester Health Services	Southwestern VT Council on Aging
Sandgate	Manchester Health Services	Southwestern VT Council on Aging
Bennington	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Dorset	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
East Dorset	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Glastenbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
North Bennington	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
North Pownal	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Pownal	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rupert	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Shaftsbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Sunderland	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
West Rupert	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Woodford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Landgrove	VNA of Vermont and New Hampshire	Senior Solutions
Peru	VNA of Vermont and New Hampshire	Senior Solutions
Readsboro	VNA of Vermont and New Hampshire	Senior Solutions
Searsburg	VNA of Vermont and New Hampshire	Senior Solutions
Stamford	VNA of Vermont and New Hampshire	Senior Solutions
Winhall	VNA of Vermont and New Hampshire	Senior Solutions
Barnet	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Burke	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Danville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
East Burke	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
East Concord	Caledonia Home Health Care	Northeastern VT Area Agency on Aging

: 2016

Town	Home Health Agency	Area Agency on Aging
East Hardwick	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
East Ryegate	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
East St. Johnsbury	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Groton	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Hardwick	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Kirby	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Lyndon	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Lyndon Center	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Lyndonville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
McIndoe Falls	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Newark	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
North Concord	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Passumpsic	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Peacham	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Ryegate	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Sheffield	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
South Ryegate	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
St Johnsbury	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
St. Johnsbury Center	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Stannard	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Sutton	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Walden	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Waterford	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
West Barnet	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
West Burke	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
West Danville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
West Stewartsville	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Wheelock	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Bolton	VNA of Chittenden and Grand Isle Counties	Age Well
Buels Gore	VNA of Chittenden and Grand Isle Counties	Age Well
Burlington	VNA of Chittenden and Grand Isle Counties	Age Well
Charlotte	VNA of Chittenden and Grand Isle Counties	Age Well
Colchester	VNA of Chittenden and Grand Isle Counties	Age Well
Essex	VNA of Chittenden and Grand Isle Counties	Age Well
Essex Junction	VNA of Chittenden and Grand Isle Counties	Age Well
Hanksville	VNA of Chittenden and Grand Isle Counties	Age Well
Hinesburg	VNA of Chittenden and Grand Isle Counties	Age Well
Huntington	VNA of Chittenden and Grand Isle Counties	Age Well
Jericho	VNA of Chittenden and Grand Isle Counties	Age Well
Jonesville	VNA of Chittenden and Grand Isle Counties	Age Well
Milton	VNA of Chittenden and Grand Isle Counties	Age Well
Richmond	VNA of Chittenden and Grand Isle Counties	Age Well
Shelburne	VNA of Chittenden and Grand Isle Counties	Age Well
South Burlington	VNA of Chittenden and Grand Isle Counties	Age Well
St George	VNA of Chittenden and Grand Isle Counties	Age Well
Underhill	VNA of Chittenden and Grand Isle Counties	Age Well
Underhill Center	VNA of Chittenden and Grand Isle Counties	Age Well
Westford	VNA of Chittenden and Grand Isle Counties	Age Well
Williston	VNA of Chittenden and Grand Isle Counties	Age Well
Winooski	VNA of Chittenden and Grand Isle Counties	Age Well
Concord	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
East Haven	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Gilman	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Granby	Caledonia Home Health Care	Northeastern VT Area Agency on Aging

: 2016

Town	Home Health Agency	Area Agency on Aging
Guildhall	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Lunenburg	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Maidstone	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Victory	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Averill	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Avery's Gore	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Beecher Falls	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Bloomfield	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Brighton	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Brunswick	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Canaan	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Ferdinand	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Island Pond	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Lemington	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Lewis	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Norton	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Bakersfield	Franklin County Home Health & Hospice	Age Well
Berkshire	Franklin County Home Health & Hospice	Age Well
East Berkshire	Franklin County Home Health & Hospice	Age Well
East Fairfield	Franklin County Home Health & Hospice	Age Well
Enosburg	Franklin County Home Health & Hospice	Age Well
Fairfax	Franklin County Home Health & Hospice	Age Well
Fairfield	Franklin County Home Health & Hospice	Age Well
Fletcher	Franklin County Home Health & Hospice	Age Well
Franklin	Franklin County Home Health & Hospice	Age Well
Georgia	Franklin County Home Health & Hospice	Age Well
Highgate	Franklin County Home Health & Hospice	Age Well
Highgate Springs	Franklin County Home Health & Hospice	Age Well
Montgomery	Franklin County Home Health & Hospice	Age Well
Montgomery Center	Franklin County Home Health & Hospice	Age Well
Richford	Franklin County Home Health & Hospice	Age Well
Sheldon	Franklin County Home Health & Hospice	Age Well
Sheldon Springs	Franklin County Home Health & Hospice	Age Well
St Albans Bay	Franklin County Home Health & Hospice	Age Well
St Albans Town	Franklin County Home Health & Hospice	Age Well
Swanton	Franklin County Home Health & Hospice	Age Well
Alburg	VNA of Chittenden and Grand Isle Counties	Age Well
Grand Isle	VNA of Chittenden and Grand Isle Counties	Age Well
Isle LaMotte	VNA of Chittenden and Grand Isle Counties	Age Well
North Hero	VNA of Chittenden and Grand Isle Counties	Age Well
South Hero	VNA of Chittenden and Grand Isle Counties	Age Well
Belvidere	Lamoille Home Health	Central VT Council on Aging
Cambridge	Lamoille Home Health	Central VT Council on Aging
Eden	Lamoille Home Health	Central VT Council on Aging
Elmore	Lamoille Home Health	Central VT Council on Aging
Hyde Park	Lamoille Home Health	Central VT Council on Aging
Jeffersonville	Lamoille Home Health	Central VT Council on Aging
Johnson	Lamoille Home Health	Central VT Council on Aging
Morristown	Lamoille Home Health	Central VT Council on Aging
Morrisville	Lamoille Home Health	Central VT Council on Aging
Moscow	Lamoille Home Health	Central VT Council on Aging
North Hyde Park	Lamoille Home Health	Central VT Council on Aging
Stowe	Lamoille Home Health	Central VT Council on Aging
Waterville	Lamoille Home Health	Central VT Council on Aging

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Town	Home Health Agency	Area Agency on Aging
Wolcott	Lamoille Home Health	Central VT Council on Aging
Orange	Central VT Home Health & Hospice	Central VT Council on Aging
Washington	Central VT Home Health & Hospice	Central VT Council on Aging
Williamstown	Central VT Home Health & Hospice	Central VT Council on Aging
Bradford	VNA of Vermont and New Hampshire	Central VT Council on Aging
Braintree	VNA of Vermont and New Hampshire	Central VT Council on Aging
Brookfield	VNA of Vermont and New Hampshire	Central VT Council on Aging
Chelsea	VNA of Vermont and New Hampshire	Central VT Council on Aging
Corinth	VNA of Vermont and New Hampshire	Central VT Council on Aging
East Barnard	VNA of Vermont and New Hampshire	Senior Solutions
East Corinth	VNA of Vermont and New Hampshire	Central VT Council on Aging
East Randolph	VNA of Vermont and New Hampshire	Central VT Council on Aging
East Thetford	VNA of Vermont and New Hampshire	Senior Solutions
Ely	VNA of Vermont and New Hampshire	Central VT Council on Aging
Fairlee	VNA of Vermont and New Hampshire	Central VT Council on Aging
Newbury	VNA of Vermont and New Hampshire	Central VT Council on Aging
North Thetford	VNA of Vermont and New Hampshire	Senior Solutions
Post Mills	VNA of Vermont and New Hampshire	Senior Solutions
Randolph	VNA of Vermont and New Hampshire	Central VT Council on Aging
Randolph Center	VNA of Vermont and New Hampshire	Central VT Council on Aging
South Strafford	VNA of Vermont and New Hampshire	Central VT Council on Aging
South Tunbridge	VNA of Vermont and New Hampshire	Central VT Council on Aging
Strafford	VNA of Vermont and New Hampshire	Central VT Council on Aging
Thetford	VNA of Vermont and New Hampshire	Senior Solutions
Thetford Center	VNA of Vermont and New Hampshire	Senior Solutions
Topsham	VNA of Vermont and New Hampshire	Central VT Council on Aging
Tunbridge	VNA of Vermont and New Hampshire	Central VT Council on Aging
Vershire	VNA of Vermont and New Hampshire	Central VT Council on Aging
Wells River	VNA of Vermont and New Hampshire	Central VT Council on Aging
West Fairlee	VNA of Vermont and New Hampshire	Central VT Council on Aging
West Newbury	VNA of Vermont and New Hampshire	Central VT Council on Aging
West Topsham	VNA of Vermont and New Hampshire	Central VT Council on Aging
Greensboro	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Lower Waterford	Caledonia Home Health Care	Northeastern VT Area Agency on Aging
Albany	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Barton	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Beebe Plain	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Brownington	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Charleston	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Coventry	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Craftsbury	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Craftsbury Common	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Derby	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Derby Line	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
East Charleston	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Glover	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Greensboro Bend	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Holland	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Irasburg	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Jay	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Lowell	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Morgan	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Morgan Center	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Newport	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging

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Town	Home Health Agency	Area Agency on Aging
Newport Center	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
North Troy	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Orleans	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Troy	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Warners Grant	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Warrens Gore	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
West Charleston	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
West Glover	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Westfield	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Westmore	Orleans/Essex Visiting Nurse Association	Northeastern VT Area Agency on Aging
Belmont	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Benson	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Bomoseen	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Brandon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Castleton	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Center Rutland	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Chittenden	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Clarendon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Clarendon Springs	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Colebrook	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Cuttingsville	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Danby	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
East Wallingford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Fair Haven	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Florence	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Forest Dale	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Hubbardton	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Hydeville	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Ira	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Mendon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Middletown Sprg	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Mount Holly	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Mount Tabor	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
North Chittenden	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
North Clarendon	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Pawlet	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Pittsford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Poultney	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Proctor	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland City	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Rutland Town	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Shrewsbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Sudbury	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Tinmouth	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Wallingford	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Wells	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
West Haven	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
West Pawlet	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
West Rutland	VNA & Hospice of the Southwest Region	Southwestern VT Council on Aging
Killington	VNA of Vermont and New Hampshire	Southwestern VT Council on Aging
Pittsfield	VNA of Vermont and New Hampshire	Senior Solutions
Sherburne	VNA of Vermont and New Hampshire	Southwestern VT Council on Aging
Statewide	Bayada	NA
Adamant	Central VT Home Health & Hospice	Central VT Council on Aging

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Town	Home Health Agency	Area Agency on Aging
Barre	Central VT Home Health & Hospice	Central VT Council on Aging
Barre Town	Central VT Home Health & Hospice	Central VT Council on Aging
Berlin	Central VT Home Health & Hospice	Central VT Council on Aging
Cabot	Central VT Home Health & Hospice	Central VT Council on Aging
Calais	Central VT Home Health & Hospice	Central VT Council on Aging
Duxbury	Central VT Home Health & Hospice	Central VT Council on Aging
East Barre	Central VT Home Health & Hospice	Central VT Council on Aging
East Calais	Central VT Home Health & Hospice	Central VT Council on Aging
East Montpelier	Central VT Home Health & Hospice	Central VT Council on Aging
Fayston	Central VT Home Health & Hospice	Central VT Council on Aging
Graniteville	Central VT Home Health & Hospice	Central VT Council on Aging
Marshfield	Central VT Home Health & Hospice	Central VT Council on Aging
Middlesex	Central VT Home Health & Hospice	Central VT Council on Aging
Montpelier	Central VT Home Health & Hospice	Central VT Council on Aging
Moretown	Central VT Home Health & Hospice	Central VT Council on Aging
North Montpelier	Central VT Home Health & Hospice	Central VT Council on Aging
Northfield	Central VT Home Health & Hospice	Central VT Council on Aging
Northfield Falls	Central VT Home Health & Hospice	Central VT Council on Aging
Plainfield	Central VT Home Health & Hospice	Central VT Council on Aging
Riverton	Central VT Home Health & Hospice	Central VT Council on Aging
Roxbury	Central VT Home Health & Hospice	Central VT Council on Aging
South Barre	Central VT Home Health & Hospice	Central VT Council on Aging
Waitsfield	Central VT Home Health & Hospice	Central VT Council on Aging
Warren	Central VT Home Health & Hospice	Central VT Council on Aging
Waterbury	Central VT Home Health & Hospice	Central VT Council on Aging
Waterbury Center	Central VT Home Health & Hospice	Central VT Council on Aging
Websterville	Central VT Home Health & Hospice	Central VT Council on Aging
Woodbury	Central VT Home Health & Hospice	Central VT Council on Aging
Worcester	Central VT Home Health & Hospice	Central VT Council on Aging
Athens	VNA of Vermont and New Hampshire	Senior Solutions
Bartonsville	VNA of Vermont and New Hampshire	Senior Solutions
Bellows Falls	VNA of Vermont and New Hampshire	Senior Solutions
Brattleboro	VNA of Vermont and New Hampshire	Senior Solutions
Brockway Mills	VNA of Vermont and New Hampshire	Senior Solutions
Brookline	VNA of Vermont and New Hampshire	Senior Solutions
Cambridge Port	VNA of Vermont and New Hampshire	Senior Solutions
Dover	VNA of Vermont and New Hampshire	Senior Solutions
Dummerston	VNA of Vermont and New Hampshire	Senior Solutions
East Dover	VNA of Vermont and New Hampshire	Senior Solutions
Grafton	VNA of Vermont and New Hampshire	Senior Solutions
Guilford	VNA of Vermont and New Hampshire	Senior Solutions
Halifax	VNA of Vermont and New Hampshire	Senior Solutions
Jacksonville	VNA of Vermont and New Hampshire	Senior Solutions
Jacksonville	VNA of Vermont and New Hampshire	Senior Solutions
Jamaica	VNA of Vermont and New Hampshire	Senior Solutions
Londonderry	VNA of Vermont and New Hampshire	Senior Solutions
Marlboro	VNA of Vermont and New Hampshire	Senior Solutions
Newfane	VNA of Vermont and New Hampshire	Senior Solutions
North Westminster	VNA of Vermont and New Hampshire	Senior Solutions
North Windham	VNA of Vermont and New Hampshire	Senior Solutions
Pikes Falls	VNA of Vermont and New Hampshire	Senior Solutions
Putney	VNA of Vermont and New Hampshire	Senior Solutions
Rawsonville	VNA of Vermont and New Hampshire	Senior Solutions
Rockingham	VNA of Vermont and New Hampshire	Senior Solutions

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Town	Home Health Agency	Area Agency on Aging
Saxtons River	VNA of Vermont and New Hampshire	Senior Solutions
Somerset	VNA of Vermont and New Hampshire	Senior Solutions
South Londonderry	VNA of Vermont and New Hampshire	Senior Solutions
South Newfane	VNA of Vermont and New Hampshire	Senior Solutions
Stratton	VNA of Vermont and New Hampshire	Senior Solutions
Townshend	VNA of Vermont and New Hampshire	Senior Solutions
Vernon	VNA of Vermont and New Hampshire	Senior Solutions
Wardsboro	VNA of Vermont and New Hampshire	Senior Solutions
West Dover	VNA of Vermont and New Hampshire	Senior Solutions
West Dummerston	VNA of Vermont and New Hampshire	Senior Solutions
West Townshend	VNA of Vermont and New Hampshire	Senior Solutions
West Wardsboro	VNA of Vermont and New Hampshire	Senior Solutions
Westminster	VNA of Vermont and New Hampshire	Senior Solutions
Westminster Station	VNA of Vermont and New Hampshire	Senior Solutions
Westminster West	VNA of Vermont and New Hampshire	Senior Solutions
Whitingham	VNA of Vermont and New Hampshire	Senior Solutions
Williamsville	VNA of Vermont and New Hampshire	Senior Solutions
Wilmington	VNA of Vermont and New Hampshire	Senior Solutions
Windham	VNA of Vermont and New Hampshire	Senior Solutions
Andover	VNA of Vermont and New Hampshire	Senior Solutions
Ascutney	VNA of Vermont and New Hampshire	Senior Solutions
Baltimore	VNA of Vermont and New Hampshire	Senior Solutions
Barnard	VNA of Vermont and New Hampshire	Senior Solutions
Bethel	VNA of Vermont and New Hampshire	Central VT Council on Aging
Bridgewater	VNA of Vermont and New Hampshire	Senior Solutions
Bridgewater Corners	VNA of Vermont and New Hampshire	Senior Solutions
Brownsville	VNA of Vermont and New Hampshire	Senior Solutions
Cavendish	VNA of Vermont and New Hampshire	Senior Solutions
Chester	VNA of Vermont and New Hampshire	Senior Solutions
Chester Depot	VNA of Vermont and New Hampshire	Senior Solutions
Gaysville	VNA of Vermont and New Hampshire	Central VT Council on Aging
Hartford	VNA of Vermont and New Hampshire	Senior Solutions
Hartland	VNA of Vermont and New Hampshire	Senior Solutions
Hartland Four Corner	VNA of Vermont and New Hampshire	Senior Solutions
Ludlow	VNA of Vermont and New Hampshire	Senior Solutions
North Hartland	VNA of Vermont and New Hampshire	Senior Solutions
North Springfield	VNA of Vermont and New Hampshire	Senior Solutions
North Stratford	VNA of Vermont and New Hampshire	Senior Solutions
Norwich	VNA of Vermont and New Hampshire	Senior Solutions
Perkinsville	VNA of Vermont and New Hampshire	Senior Solutions
Plymouth	VNA of Vermont and New Hampshire	Senior Solutions
Pomfret	VNA of Vermont and New Hampshire	Senior Solutions
Proctorsville	VNA of Vermont and New Hampshire	Senior Solutions
Quechee	VNA of Vermont and New Hampshire	Senior Solutions
Reading	VNA of Vermont and New Hampshire	Senior Solutions
Rochester	VNA of Vermont and New Hampshire	Central VT Council on Aging
Royalton	VNA of Vermont and New Hampshire	Central VT Council on Aging
Sharon	VNA of Vermont and New Hampshire	Central VT Council on Aging
South Pomfret	VNA of Vermont and New Hampshire	Senior Solutions
South Reading	VNA of Vermont and New Hampshire	Senior Solutions
South Royalton	VNA of Vermont and New Hampshire	Central VT Council on Aging
South Woodstock	VNA of Vermont and New Hampshire	Senior Solutions
Springfield	VNA of Vermont and New Hampshire	Senior Solutions
Stockbridge	VNA of Vermont and New Hampshire	Central VT Council on Aging

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Town	Home Health Agency	Area Agency on Aging
Taftsville	VNA of Vermont and New Hampshire	Senior Solutions
Tyson	VNA of Vermont and New Hampshire	Senior Solutions
Weathersfield	VNA of Vermont and New Hampshire	Senior Solutions
West Hartford	VNA of Vermont and New Hampshire	Senior Solutions
West Windsor	VNA of Vermont and New Hampshire	Senior Solutions
Weston	VNA of Vermont and New Hampshire	Senior Solutions
White River Jct	VNA of Vermont and New Hampshire	Senior Solutions
Wilder	VNA of Vermont and New Hampshire	Senior Solutions
Windsor	VNA of Vermont and New Hampshire	Senior Solutions
Woodstock	VNA of Vermont and New Hampshire	Senior Solutions