

Choices for Care 101

Case Manager Training

March 20th-21st – Burlington

March 27th-28th – Rutland

CFC 101 TRAINING

DAY 1

- I. Introductions
- II. Program Overview
- III. Eligibility
- IV. Settings
- V. Services & Providers
- VI. Case Management Responsibilities

Choices for Care Resources

- CFC Regulations
- CFC Operational Protocol
- CFC Program Manual
- Division of Disabilities and Aging Services
Website <http://www.ddas.vermont.gov/>
- Individualized Services Unit
 - Director, Manager, Supervisors, LTCCCs

Choices for Care

What is Choices for Care (CFC)?

- CFC is an 1115 Research and Demonstration Medicaid Waiver approved by the Center for Medicare and Medicaid Services (CMS).
- CFC provides Long-Term Care Services for adult Vermonters with physical disabilities.
- CFC began October 1, 2005

Goals

- Provide choice and equal access to long-term care
- Create a balanced system
- Serve more people
- Manage the costs of long term care
- Improve the system
- Prevention (Moderate Needs)

Mission Statement

DAIL Mission Statement

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

Core Principles

DAIL Core Principles

- **Person-Centered**
The individual will be at the core of all plans and services.
- **Respect**
Individuals, families, providers and staff are treated with respect.
- **Independence**
The individual's personal and economic independence will be promoted.
- **Choice**
Individuals will have options for services and supports.
- **Self-Determination**
Individuals will direct their own lives.
- **Living Well**
The individual's services and supports will promote health and well-being.
- **Contributing to the Community**
Individuals are able to work, volunteer, and participate in local communities.
- **Flexibility**
Individual needs will guide our actions.
- **Effective and Efficient**
Individuals' needs will be met in a timely and cost effective way.
- **Collaboration**
Individuals will benefit from our partnerships with families, communities, providers, and other federal, state and local organizations.

General Policies

- Long-term care services shall be based on person-centered planning and shall be designed to ensure quality and protect the health and welfare of the individuals receiving services.
- Long-term care services shall be provided in a cost effective and efficient manor, preventing duplication, unnecessary costs, and unnecessary administrative tasks. The Department shall manage long-term care services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals.

(Choices for Care Regulations)

Long Term Care Clinical Coordinators (LTCCCs)

LTCCCs are Registered Nurses located regionally that work for DAIL in the CFC program.

LTCCC Responsibilities:

- Process Choices for Care (Highest, High) applications
- Face-to-face clinical assessment on all applicants
- Options Education
- Clinical eligibility determinations and notifications
- Process and authorize Service Plans (HB&ERC)
- Service Plan Utilization Review
- High Needs wait list score sheet
- Verify Medicaid status for new applicants

LTCCC Responsibilities (cont.)

LTCCC Responsibilities (cont):

- Annual clinical eligibility (paper) reviews
- Process changes in settings, Highest Paid Provider etc.
- Data enter Choices for Care application and service plan information into SAMS database
- Facilitate local Choices for Care team meetings
- Process notices, denials and termination
- Participate in appeals
- Manage High needs wait list
- Technical assistance to consumers, providers and case managers
- Outreach

Eligibility

To be eligible an individual must:

- Be a Vermont resident, and
- Be 18 years of age or older, and
- Have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging, and
- Meet the clinical criteria for the program (Highest or High), and
- Meet all financial and non-financial criteria for VT Long-Term Care Medicaid, and
- Choose one of three settings in which to receive approved long-term care services:
 - Home-Based Setting
 - Enhanced Residential Care Setting
 - Nursing Facility Setting

Eligibility Limitations

Eligibility Limitations:

- Choices for Care shall not replace or supplant services otherwise provided under other 1915c Medicaid waivers or other 1115 Medicaid waivers (e. g. Community Rehabilitation and Treatment). Individuals whose need for services is due to mental retardation, autism, or mental illness shall not be eligible for services.
- Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicaid, Medicare and VA benefits.

(Choices for Care Regulations)

HIGHEST NEED Clinical Eligibility

HIGHEST NEED Clinical Criteria (CFC Regulations)

1. Activities of Daily Living (ADLs)

- Individuals who require extensive or total assistance with at least one of the following Activities of Daily Living (ADLs): *toilet use; eating; bed mobility; or transfer*, and require *at least* limited assistance with any other ADL.

HIGHEST NEED Clinical Eligibility

HIGHEST NEED Clinical Criteria (cont.)

2. Cognition & Behavior

- Individuals who have a severe impairment with decision-making skills or a moderate impairment with decision-making skills and one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered: *Wandering, Resists Care, Behavioral Symptoms, Verbally Aggressive Behavior Physically Aggressive Behavior*

HIGHEST NEED Clinical Eligibility

HIGHEST NEED Clinical Criteria (cont.)

3. Conditions & Treatments

- Individuals who have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis: *Stage 3 or 4 Skin Ulcers, Ventilator/ Respirator, IV Medications, Naso-gastric Tube Feeding, End Stage Disease, Parenteral Feedings, Suctioning, 2nd or 3rd Degree Burns.*

HIGHEST NEED Clinical Eligibility

HIGHEST NEED Clinical Criteria (cont.)

4. Unstable Medical Conditions

- Individuals who have an unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following: *Dehydration, Aphasia, Vomiting, Internal Bleeding, Transfusions, Wound Care, Aspirations, Oxygen, Pneumonia, Dialysis, Multiple Sclerosis, Quadriplegia, Chemotherapy, Septicemia, Cerebral Palsy, Respiratory Therapy, Open Lesions, Radiation Therapy, Tracheotomy, Gastric Tube Feeding.*

HIGH NEEDS Clinical Eligibility

HIGH NEEDS Clinical Criteria (CFC Regulations)

1. Activities of Daily Living (ADLs)

- Individuals who require extensive to total assistance on a daily basis with at least one of the following ADLs: *Bathing, Eating, Dressing, Toilet Use, Physical Assistance to Walk.*

HIGH NEEDS Clinical Eligibility

HIGH NEEDS Clinical Criteria (cont.)

2. Skilled Teaching - Daily

- Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following: *Gait training, Range of Motion, Speech, Bowel or Bladder Training.*

HIGH NEEDS Clinical Eligibility

HIGH NEEDS Clinical Criteria (cont.)

3. Cognition

- Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following (ADL): *Bathing, Eating Transferring, Dressing, Toilet Use, Personal Hygiene*

HIGH NEEDS Clinical Eligibility

HIGH NEEDS Clinical Criteria (cont.)

4. Behaviors

- Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:
Constant or Frequent Wandering, Behavioral Symptoms, Physically Aggressive or Verbally Aggressive Behavior.

HIGH NEEDS Clinical Eligibility

HIGH NEEDS Clinical Criteria (cont.)

5. Conditions & Treatments

- Individuals who have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including, but not limited to, the following: *Wound Care, Medication Injections, Parenteral Feedings, Tube Feedings, Suctioning, End Stage Disease, Severe Pain Management.*
- **AND** who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis.

Wait List

- Choices for Care has the authority to activate a High Needs Wait List when necessary.
- When this occurs, only applicants that meet Highest Needs criteria are enrolled in Choices for Care.
- Applicants that meet High Needs criteria are placed on a wait list.
- Currently, (as of 2/1/08) there is a High Needs wait list in Choices for Care.
- If an applicant is granted special circumstance, they are enrolled in the Highest Needs Group.

Special Circumstance

Special Circumstance Criteria:

In order for an applicant to be enrolled in the Highest Needs group due to a special circumstance, the Department must determine that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. The Department may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

- Loss of primary caregiver (e. g. hospitalization of spouse, death of spouse);
- Loss of living situation (e. g. fire, flood);
- The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
- The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.).

(Choices for Care Regulations)

Financial Eligibility

- Individuals must be eligible for Long-Term Care Medicaid to meet the financial eligibility requirements for Choices for Care.
- The Department for Children and Families (DCF) Economic Services Division (ESD) shall determine eligibility for applicants for the Highest and High Needs groups according to DCF Supplemental Security Income (SSI)-related Medicaid regulations applicable to long-term care eligibility.
- Some people may have a monthly patient share.
- Estate Recovery rules apply.

Financial Eligibility (cont.)

To be financially eligible?

- Meet CFC Clinical Criteria
- Be a Vermont resident
- Age 65 or older, or blind or disabled according to Social Security standards.
- Meet LTC institutional income standard
- Meet LTC resource standards
- Meet permissible transfer rules (Rules M440-M440.44)
- Provide proof of asset transfers in the 3 years prior to the date of application*
- Provide proof of any irrevocable trusts created within 5 years of the date of application, including an accounting of all assets placed in or removed from the trust in the last 5 years.

What Have You Learned So Far?

1. What is the name of the long-term care program in Vermont?
2. What is the minimum age to be eligible for the long-term care program?
3. What population does the VT long-term care program serve?
4. Where can eligible consumers receive their long-term care services?
5. Who determines if an applicant is clinically eligible for long-term care services?
6. Who determines if an applicant is financially eligible for long-term care services?

Answers

1. What is the name of the Long-Term Care Medicaid Program in Vermont? [Choices for Care.](#)
2. What is the minimum age to be eligible for the long-term care program? [18](#)
3. What population does the VT long-term care program serve? [Adults with physical disabilities.](#)
4. Where can eligible consumers receive their long-term care services? [Home, Approved Residential Care Home, Assisted Living Residence or Nursing Facility](#)
5. Who determines if an applicant is clinically eligible for long-term care services? [Long Term Care Clinical Coordinator \(LTCCC\)](#)
6. Who determines if an applicant is financially eligible for long-term care services? [The Department for Children and Families, Economic Services Division. \(DCF/ESD\)](#)

Settings

Eligible CFC applicants may choose to receive their CFC services in:

- A Nursing Facility (NF)
- Home Setting (HB)
- Enhanced Residential Care Setting (ERC)

The services offered in the different settings are not the same.

Universal Provider Qualifications

To become a CFC Provider they must:

- Be authorized by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) to provide CFC services; and
- Demonstrate compliance with provider standards, including applicable Federal and State regulations; and
- Maintain an up-to-date Provider Agreement with DAIL, if applicable; and
- Be enrolled with Electronic Data Systems (EDS) as a Vermont Medicaid provider.

Universal Provider Standards

Approved CFC Providers Must:

1. Comply with all applicable provider qualifications and provider standards.
2. Ensure that all staff with direct participant contact have passed a background check, according to the DAIL Background Check Policy (April 1, 2006).
3. Provide applicable services according to service principles, definitions, standards, approved activities, and limitations.
4. Provide services in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks.
5. Implement structured internal complaint and appeals procedures.
6. Fully inform individuals of their rights and responsibilities in working with the agency, including both internal and formal waiver complaint and appeal procedures.

Universal Provider Standards

7. Encourage and assist the participant to direct as much of her/his own care as possible.
8. Implement policies and procedures that will be used to supervise and/or monitor services.
9. Follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting of abuse, neglect, and exploitation.
10. Maintain all financial records in accordance with Generally Accepted Accounting Principles (GAAP) for period of seven (7) years.
11. Maintain all records pertaining to delivery and documentation of CFC services for a minimum of three (3) years.
12. Demonstrate to the DAIL that they have sufficient expertise and capacity to meet the needs of the target population, including effective working relationships with other local or regional providers and agencies.

Universal Provider Standards

13. Ensure services are provided as defined in the approved CFC Service Plan.
14. Ensure that staff have the skills and/or training required to meet the needs of the participant.
15. Maintain accurate and complete documentation of services provided to the individual.
16. Report any concerns about services or the individual's status and condition to the individual's case manager, if the individual is in the home-based or ERC setting.
17. Ensure that the volume of services and rate charged to the State are based on services actually provided to the participant, within the limits specified in the approved Service Plan. (See *Enrollment & Billing Procedures*)

Universal Provider Standards

18. Avoid conflicts of interest between the interests of the individual and the interests of the provider and its staff.
19. Assist the State in ensuring that services are provided in compliance with the standards, policies and procedures established by the State. This includes participating in structured evaluation activities developed by the State.
20. Abide by principles of confidentiality and all applicable confidentiality policies and laws. (i.e. HIPAA)
21. Comply with all applicable laws and regulations regarding employment, including the provision of workers compensation insurance and unemployment insurance to employees.

Nursing Facility Services

NF services include the following activities, reimbursable under the daily nursing facility rate:

- Room and Board
- Skilled Nursing
- Personal Care
- Medication Management and pharmacy services
- Social Worker Services & Recreation Activities
- 24-Hour On-Site Nursing Supervision
- Laundry Services
- Housekeeping Services
- Transportation Services
- Physical Therapy, Occupational Therapy and Speech Therapy
- Nutritional and Dietary Services
- Maintenance of Resident Clinical Records.

Nursing Facility FACTS

- Must be licensed by the state of VT.
- Are surveyed by the Division of Licensing and Protection.
- Must follow specific State and Federal regulations.
- Must bill Medicare or other insurance first if applicable.
- Case Mix rate is set by the VT Division of Rate setting.
- Each facility has their own daily rate.
- Facilities may request a special rates for people with unique physical or behavioral needs. Two separate processes.
- Room and board included in the daily rate.
- Use the Minimum Data Set (MDS) assessment tool, mandated by the federal government.

Enhanced Residential Care (ERC) Services

The following activities are provided by the ERC Provider:

- **Nursing Overview:** Assessment, health monitoring, and routine nursing care is provided or supervised by a Licensed Registered Nurse and is available one (1) hour per week per ERC resident as needed.
- **Personal Care Service (ADL):** Assistance with meals, movement, bathing, dressing, transferring, personal hygiene, grooming and toileting is available for two (2) hours per day per ERC resident as needed.
- **Medication Management:** The process of assisting residents to self-administer their medications or administering medications, under the supervision and delegation by the RN.
- **Social & Recreation Activities:** Social or recreational activities, either in a group setting or individually, must be offered daily. Activities may be in the home or community.
- **24-Hour On-Site Supervision:** ERC staff must be on duty seven (7) days a week, twenty-four (24) hours a day.
- **Laundry Services:** Laundry services shall be provided as well as the opportunity to launder ones own clothing if desired.
- **Household Services:** Bed making and household cleaning shall be provided.

Other:

- **Case Management Services:** Maximum of 48 hours per calendar year is provided by Area Agency on Aging or Medicare Certified Home Health Agency.

ERC - Other Services

The following services are provided to all ERC residents but are not reimbursed for through CFC:

- **Transportation Services**: As outlined in the Residential Care Home regulations, the home shall provide, without charge, 4 trips per month, 20 miles round trip. After the 4 trips per month, the home may charge the resident the amount agreed upon in the admission agreement. Medicaid transportation may be utilized after the 4 trips if medically necessary.
- **Meals**: Three meals and snacks shall be provided daily.

ERC FACTS

- Must be licensed by the State of VT as a Level III Residential Care Home or Assisted Living Residence.
- Are surveyed by the Division of Licensing and Protection.
- Must follow specific State Regulations.
- May bill for ACCS services.
- Individual pays for Room and Board.
- Use the Comprehensive Resident Assessment tool (CRA).
- Daily Tier rate based on CRA.

ERC Reimbursement Rates

Rates effective 7/1/07:

- Tier 1: \$48.76/day RCH, \$53.95/day ALR
- Tier 2: \$55.51/day RCH, \$60.69/day ALR
- Tier 3: \$62.25/day RCH, \$67.44/day ALR

- ACCS: \$34.25/day

Home-Based Services

Home-Based Services can be provided:

- in the individual's own home (house/apt, etc),
- in the home of a relative, or
- in the home of someone not related.

Home-Based Options:

- “Traditional” fee-for-service option (agency, consumer, or surrogate directed)
- Flexible Choices
- PACE (Chittenden/Rutland only)
- Pending: 24-hour care option

Home-Based “Traditional” Option

“Traditional” Service Options:

- Personal Care
- Adult Day
- Respite/Companion
- Assistive Devices/Home Modifications
- Personal Emergency Response
- Case Management

Personal Care Services

Definition: “Personal Care Services” assist individuals in the home-based setting with activities of daily living (ADL) and instrumental activities of daily living (IADL) that are essential to the health and welfare of the individual. The amount of personal care is based on the individual’s assessed needs.

Approved activities:

- Activities of Daily Living
- Instrumental Activities of Daily Living

Personal Care - ADLs

Activities of Daily Living (ADL) include the following:

- Dressing
- Bathing
- Personal Hygiene
- Bed Mobility
- Toileting
- Assistance with Adaptive Devices
- Transferring
- Mobility
- Eating

Personal Care - IADLs

Instrumental Activities of Daily Living (IADL) include:

- Meal Prep
- Medication Management
- Phone Use
- Money Management
- Household Maintenance
- Housekeeping/Laundry
- Shopping
- Transportation
- Care of Adaptive Equipment

Personal Care Limitations

Limitations:

1. Personal Care Services are limited to the maximum hours allocated on the DAIL approved Service Plan.
2. Instrumental activities of daily living (IADLs), not including meal preparation and medication management, are limited to 5.5 hours per week as described on the Personal Care Worksheet.
3. A spouse or Civil Union partner shall not be paid to provide help with Instrumental Activities of Daily Living.
4. Personal Care Services shall not be furnished to individuals who are inpatients of a hospital or nursing facility.
5. A legal guardian, appointed by probate court, may not be paid to provide Personal Care Services.

Personal Care Limitations

Limitations (cont.):

6. A person who receives wages to provide Personal Care Services may not simultaneously receive mileage reimbursement as a volunteer driver through the VT Medicaid transportation benefit.
7. CFC shall not be used to provide Personal Care Services that are otherwise being purchased privately or paid for through another funding source.
8. Assistance with meal preparation does not include the cost of food.
9. Medicare Certified Home Health Agencies may place limitations on the delegation of certain Personal Care Services activities according to VT Statute Title 26, Chapter 28 and the State of VT Board of Nursing Administrative Rules (e.g. medication handling).

Personal Care Providers

Personal Care Services are provided by:

- Home Health Agency
- Consumer Employer Directed
- Surrogate Employer Directed

Personal Care Rates

Rates effective 10/7/07:

- Home Health Agency: \$25.96/hr
- Consumer/Surrogate: \$11.56/hr
- ISO Rate (CD/SD only): \$45/month

- **NOTE:** Consumer/Surrogate Employee Pay: \$10.38/hr

Home Health Agency FACTS

Home Health Agencies:

- Must follow State Designation regulations.
- Are surveyed by the Division of Licensing and Protection.
- Many are accredited.
- Must supervise Personal Care Attendants (PCAs) every 60 days.
- Pay to the employee (PCA) is determined by the agency.

Respite Care Services

Definition: “Respite Care Services” are services provided to individuals who are unable to care for themselves, and are furnished on a short-term basis because of the absence or need for relief for those persons who normally provide unpaid care. A maximum of 720 hours a calendar year is available based on assessed need for respite services. The individual must have an unpaid primary caregiver to be eligible for this service.

Approved activities:

- Personal Care
- Supervision
- Socialization

Respite Care Service Limitations

Limitations:

1. Respite Care Services are limited to individuals who have identified an unpaid caregiver who will benefit from respite.
2. Respite Care Services are limited to a maximum of 720 hours (30 days) per calendar year in combination with Companion Services.
3. Respite Care Services provided in an Enhanced Residential Care setting must be utilized in 24/hour blocks.
4. A spouse or a Civil Union partner shall not be paid to provide respite care services.
5. A legal guardian, appointed by the probate court, shall not be paid to provide respite care services.

Respite Care Service Limitations

Limitations (cont.):

6. Respite Care Services shall not be provided to a participant while out of the state of Vermont for more than 7 consecutive days.
7. Respite Care Services do not include the cost of room and board except when provided as part of respite care furnished in a Nursing Facility setting.
8. CFC shall not be used to provide Respite Care Services that are otherwise being purchased privately or paid for through another funding source.

Respite Providers

Respite Providers:

- Home Health Agency
- Consumer/Surrogate Directed
- ERC provider (Level III & ALR)
- Adult Day provider

NOTE: For individuals in a home-based setting they may change CFC setting to a Nursing Facility for “respite” in a nursing facility.

Respite Care Rates

- Home Health Agency: \$20.76/hr
- Consumer/Surrogate: \$9.84/hr
- Adult Day: \$13.00/hr
- Residential Care Home/ALR: \$91.30/day
- ISO Rate (CD/SD only): \$45/month

- Consumer/Surrogate Employee Pay: \$8.82/hr

Companion Services

Definition: “Companion Services” include non-medical care, supervision and socialization provided to individuals on a short-term basis, who are unable to care for themselves and are socially isolated.

Approved Activities:

- Limited Personal Care or Household Tasks
- Supervision
- Socialization

Companion Services Limitations

Limitations:

1. Companion Services are limited to a maximum of 720 hours per calendar year in combination with Respite Care Services.
2. Assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) shall be limited by the skills and abilities of employees providing companion services, as determined by the provider.
3. A spouse or a Civil Union partner shall not be paid to provide respite care services.
4. A legal guardian, appointed by probate court, shall not be paid to provide respite care services.

Companion Service Limitations

Limitations (cont.):

5. Companion Services shall not be provided to a participant while out of the state of Vermont for more than 7 consecutive days.
6. CFC shall not be used to provide Companion Services that are otherwise being purchased privately or paid for through another funding source.

Companion Service Rates

Rates effective 10/7/07:

- Home Health Agency Companion: \$20.76/hr
- Consumer/Surrogate Companion: \$9.84/hr
- Sr. Companion Program: \$7.76
- ISO Rate (CD/SD only): \$45/month

- **NOTE:** Consumer/Surrogate Employee Pay:
\$8.82/hr

Adult Day Services

Definition: Adult Day Services are community-based non-residential services designed to assist adults to remain as active in their communities as possible, providing a wide variety of social and health related activities. The amount of Adult Day Services is based on the individual's assessed need and availability of local providers.

Approved activities:

- Assessment
- Personal Care
- Therapies
- Activities
- Meals
- Social Outings
- Nursing Overview
- Respite

Adult Day Limitations

Limitations:

1. Adult Day Services are limited to individuals approved by DAIL for services in the home-based setting.
2. Adult Day Services are limited to a maximum of 12 hours per day.
3. Adult Day Services are limited to the hours of operation and capacity of the adult day provider.
4. Adult Day Services are limited to the number of hours indicated on the approved CFC Service Plan.
5. Meals provided as part of Adult Day Services shall not constitute a “full nutritional regimen” for the day.

Adult Day Limitations

Limitations (cont.):

6. Transportation services are not included and are not reimbursed as part of Adult Day Services. The costs of transporting participants to and from the Adult Day Services site may be eligible for reimbursement under the Medicaid State Plan, as a transportation service.
7. Adult Day Services shall not be reimbursed for individuals residing in a licensed facility (hospital, nursing facility, residential care home, assisted living residence).

Adult Day FACTS

- Providers must be approved by DAIL.
- Must follow “Standards for Adult Day Services in Vermont”.
- Have a maximum building capacity.
- Often provide a free trial visit.
- A very effective resource for social activities, respite and supervision.
- Rate effective 7/1/07 is \$13.00/hr.

Assistive Devices & Home Modifications (AD/HM)

Definition:

1. An “Assistive Device” is defined as an item, whether acquired commercially or off the shelf, which is used to increase, maintain, or improve functional capabilities. Such devices are intended to replace functional abilities lost to the individual because of his or her disability and must be used in performing Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL).
2. A “Home Modification” is defined as a physical adaptation to the home which is necessary to allow safe access to and use of, the individual’s primary living space, bathroom, kitchen, or main exit/entrance to the home.

AD/HM (cont.)

Assistive Devices and Home Modifications must be approved by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

- All applicable medical and manufacturing standards.
- All applicable State and local building codes.
- AAA and HHA Case Management provider types are approved to bill for Assistive Devices and Home Modifications when authorized by DAIL and identified on the individual's Service Plan.

AD/HM (cont.)

Approved List:

1. Adaptive eating utensils
2. Adaptive kitchen utensils
3. Adaptive sinks/faucets
4. Adaptive telephones with large numbers
5. Air conditioner: for individuals with Chronic Obstructive Pulmonary Disease (COPD) *only if denied by Medicaid and Medicare and determined necessary for maintaining or improving functional abilities.*
6. Bath/shower chair: with or without transfer bench *(for individuals with dual Medicare/Medicaid coverage only)*
7. Bed rails/U-bar: for the purpose of transferring and/or bed mobility *only*, **NOT** to be used as a restraint

AD/HM (cont.)

Approved List (cont.):

8. Doorways widened for accessibility
9. Dressing aids
10. Gait belt
11. Grab bars/“Super pole”
12. Hand held shower unit
13. Medication reminder units
14. Raised toilet seat (*for individuals with dual Medicare/Medicaid coverage **only***)
15. Ramp for primary entrance/exit
16. Reacher/grabber

AD/HM (cont.)

Approved List (cont.):

17. Repairs/modifications to items purchased by waiver or “pre-approved items” that were purchased privately
18. Roll-in shower unit
19. Seat lift chairs for the purpose of transferring: purchase of the chair **only** after Medicare/Medicaid pays for lift mechanism (*for individuals with dual Medicare/Medicaid coverage only*)
20. Shampoo tray for bed bath
21. Walker basket
22. Walker wheels
23. Wander devices: for individuals with dementia **only**

AD/HM Limitations

Limitations:

- Expenditures for assistive devices and home modifications are limited to a maximum of \$750.00 per calendar year.
- Only devices that are not otherwise covered by Medicare, Medicaid, or private insurance will be considered.
- Funds may not be used to purchase assistive devices or home modifications that are not of direct benefit to the individual.
- Consistent with Centers for Medicare and Medicaid Service's (CMS) constraints on the definition of assistive devices, funds cannot be used to purchase, repair, or otherwise pay for dentures, hearing aids or glasses.

AD/HM Limitations

Items Not Approved:

1. Appliances (non-adapted)
2. Automobiles
3. Batteries
4. Blood pressure monitors
5. Clothing
6. Computer/computer software
7. Dentures/Dental Care
8. Eating utensils (non-adapted)
9. Exercise equipment
10. Eye glasses
11. Fans
12. Furniture (non-adapted)

AD/HM Limitations

Items Not Approved (cont.):

13. Golf carts
14. Health club memberships
15. Hearing aids
16. Heating pads
17. Home maintenance/repairs/remodeling/new construction
18. Hospital bed
19. Incontinence supplies
20. Kitchen utensils (non-adapted)
21. Massage devices
22. Mattresses
23. Medical supplies

AD/HM Limitations

Items Not Approved (cont.):

24. Medicare and Medicaid covered items
25. Medications (prescribed or over-the-counter)
26. Modified secondary home entrance/exit
27. Muscle stimulators
28. Nutritional supplements
29. Orthotics (prosthetic shoes, lifts, braces)
30. Oxygen equipment
31. Pads/Pillows/Cushions
32. Physical therapy devices
33. Ramp enclosure
34. Repairs/modifications to items purchased by Medicare, Medicaid or private insurance

AD/HM Limitations

Items Not Approved (cont.):

35. Rolling chairs
36. Scales
37. Scooter/carts for outdoor transportation
38. Secondary ramp
39. Service/support animals
40. Smoke alarms
41. Support hose/stockings
42. Swimming pool accessories
43. Therapies
44. Toothbrushes (non-adapted)
45. Wheelchair reserve/backup

AD/HM - Other

- Items that do not appear on the above “approved” and “not approved” lists must be “pre-approved” by DAIL.
- Determinations will be made based on the individual’s unique circumstances as they apply to the current Assistive Devices/Home Modifications definitions, policies and procedures.
- A denial letter must accompany requests for items generally covered by Medicare, Medicaid, or private insurance.

AD/HM FACTS

- Vendors are not direct CFC providers.
- AD/HB services are coordinated and billed through the case management agency.
- Items are paid at the prevailing rate for the item or service.
- Case Managers must assure the item is not covered by Medicare or other insurance.
- Must be cost effective.

Go to Tab 6 for “Assistive Devices and Home Modifications” form.

Personal Emergency Response System (PERS)

Definition:

“Personal Emergency Response System” (PERS) is an electronic device that enables individuals at high risk of institutionalization to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Professionally trained PERS staff assess the nature of the emergency and obtain appropriate help for the individual as necessary.

PERS Limitations

Limitations:

1. PERS services as defined in this section are limited to individuals approved by DAIL for services in the Home-Based setting.
2. PERS services are limited to a maximum of twelve (12) months of service per calendar year.
3. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time.
4. PERS services are limited to individuals who are able to effectively utilize PERS equipment.

PERS FACTS

- Must follow PERS standards.
- Some providers are statewide, while other are local.
- Rate: \$55 installation, \$30/mo ongoing
- Providers:
 - Lifeline (statewide)
 - Link to Life (statewide)
 - Rutland Regional Medical Center
 - Southwest VT Health Auxiliary

Case Management Services

Definition: “Case Management Services” assist individuals in gaining access to needed Choices for Care (CFC), VT Long-Term Care Medicaid services as well as other medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case Management Services provide detailed needs assessment and assist the individual in creating a comprehensive CFC Service Plan. Case Management Services provide ongoing assessment and monitoring. Case Management Services assist the Department of Disabilities, Aging and Independent Living (DAIL) in monitoring the quality, effectiveness and efficiency of CFC services.

Case Management Activities

Approved Activities:

- Assessment
- Care-Planning
- Service Coordination
- Information and Referral
- Monitoring
- Consumer & Surrogate Employer Certification
- Documentation

Case Management Limitations

Limitations:

1. Case Management Services are limited to the “approved activities” for individuals authorized by DAIL for Choices for Care in the Home-Based or Enhanced Residential Care (ERC) setting.
2. Case Management Services are limited to a maximum of 48 hours per individual per calendar year. The State may approve higher volumes of case management services on a case-by-case basis, via the Service Plan approval process. The case manager must submit a brief written justification of the need for a higher volume of case management with the Service Plan document.

Case Management Limitations

Limitations (cont.):

3. Case Management Services may not be delegated to another case manager except under short-term, temporary situations.
4. Case Management Services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing facility or hospital, when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing facility, as a single **claim**.

Case Management FACTS

- Must follow DAIL “Case Management Standards”
- Must follow DAIL Certification procedures
- Mandated Reporters: Adult Protective Services
- Rate effective 7/1/07: \$67.44/hr

Consumer/Surrogate Directed FACTS

Consumer/Surrogate Directed:

- Employers must be certified by the Case Manager.
- Surrogate employers are often a family member, guardian or friend who knows the individual well.
- Being a surrogate is voluntary and is not paid to be the employer.
- Employers must sign an agreement of responsibilities.
- Employers and Employees must enroll with the payroll agent (ARIS).
- Employees do not get paid until enrollment paperwork is complete and the payroll agency has an approved Service Plan.
- Employees are not paid if the patient share is not paid.
- Pay rate to the employee is set by DAIL.

CD/SD Employer Eligibility

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

CD/SD Employer Eligibility (cont.)

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

Go to Tab 6 Employer Certification Form

CD/SD Employer Responsibilities

EMPLOYER Responsibilities:

1. Understand and follow program requirements.
2. Recruit and select qualified employee(s) that are 18 years of age or older.
3. Notify selected employee(s) of their responsibilities.
4. Assure that employment forms are completed and submitted to the payroll agent (SeeChapter VIII).
5. Train employee(s) to perform specific tasks as needed.

CD/SD Employer Responsibilities

EMPLOYER Responsibilities (cont.):

6. Develop a work schedule based on the approved Service Plan.
7. Maintain updated copies of approved waiver Service Plan.
8. Arrange for substitute or back-up employees as needed.
9. Develop and maintain a list of tasks for the employee(s) to perform based on the Personal Care Worksheet.
10. Authorize employee(s) timesheets (based on the approved Service Plan and actual time worked).

CD/SD Employer Responsibilities

EMPLOYER Responsibilities (cont.):

11. Maintain copies of all employee(s) timesheets
12. Perform supervisory visits in the home of the individual at least once every thirty (30) days in order to assure that tasks are performed by the employee correctly and completely
13. Evaluate employee(s) performance
14. Provide ongoing performance feedback to employee(s)
15. Terminate employee(s) employment when necessary
16. Notify the payroll agent of any necessary changes

CD/SD Employer Responsibilities

EMPLOYER Responsibilities (cont.):

17. Participate in the assessment and reassessment of CFC eligibility
18. Communicate with the case manager on a regular basis (See Chapter IX.)
19. If applicable, assure a monthly patient share is paid to the payroll agent (See Chapter VIII.)
20. Track use of Respite and Companion service hours, so as not to exceed 720 hours a calendar year (See Chapter IV)
21. Avoid conflict of interest with employees, the individual and/or other participating agencies

CD/SD Limitations

CD/SD Limitations:

1. Consumer and surrogate employers are **not** paid by the CFC to direct and manage services.
2. An individual's legal guardian (appointed by a probate court) may **not** be paid to provide services under CFC.
3. An employee who is paid by CFC to provide services for the individual may **not** also serve as the surrogate employer.
4. Employees must be 18 years of age or older.
5. CFC only provides services and care for the individual who has been found eligible. Therefore, services are **restricted to the benefit of the individual.**

CD/SD Limitations

CD/SD Limitations (cont.):

6. An individual's spouse or civil union partner may **not** be paid to provide companion services or respite services under the CFC program.
7. An individual's spouse or civil union partner may **not** be paid to provide personal care assistance with Instrumental Activities of Daily Living such as meal prep, medication management, phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.
8. Individuals may remain eligible for CFC up to **30 days** while absent from the state of Vermont.

CD/SD Limitations

CD/SD Limitations (cont.):

9. Employees are not paid to provide services while the individual is admitted to a hospital or nursing facility.
10. Surrogate employers shall not be certified to manage CFC services for more than two (2) individuals at one time.
11. CFC shall not be used to provide services that are otherwise being purchased privately or through another funding source.

CD/SD Limitations

CD/SD Limitations (cont.):

12. Persons with any of the following may not be paid to provide services under the CFC program (*DAIL Background Check Policy, April 1, 2006*):

- a substantiated history of abuse, neglect, or exploitation of an adult or child;
- exclusion from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; or
- a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust.

CD/SD Employee Requirements

CD/SD Employee Requirements:

- be aged 18 years old or over, and
- be able and willing to perform required tasks, and
- be legally eligible to work in the state of Vermont
- On a case-by-case basis, the Department of Disabilities, Aging and Independent Living (DAIL) may approve an employee under the age of 18 to provide services when the employee has the experience and skills specific to working with elders with functional limitations or individuals with disabilities. Requests must be presented in writing to DAIL.

Flexible Choices (FC) Option

Definition: Flexible Choices is a consumer or surrogate directed home and community based option which converts an individual's Home Based Service Plan into a cash allowance. Working with a consultant, the individual develops a budget which details expenditure of the allowance and guides the individual's acquisition of services to meet their needs.

FC Consultant Services

Consultants are responsible for:

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

FC Consultant Services (cont.)

Consultants are not responsible for:

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

FC Budget Items

Budget Items:

- Administrative fees
- Personal care
- Adult Day Services
- Other Services: Activities provided by a professional e.g. nursing or occupational therapy.
- Goods: These are all other items and activities that do not fit into any other category. This includes tangible items, but also includes things such as health club memberships, yard and home maintenance and transportation.
- Cash: The participant may receive up to \$50 per two week period in cash. This is to purchase goods or services that are not amenable to billing or vouchers, such as cab rides or the neighbor who shovels the sidewalk.

FC Budget Items

Budget Items (cont.):

- **Savings:** If a participant does not spend the entire allowance in a two week period, the unspent sum may be carried over to the future as savings. Participants may not carry over more than \$500 in savings from one state fiscal year (July 1 – June 30) to the next. There are two kinds of savings:
 - *Specified Savings:* These are savings that are directed towards a specific purchase. There is no limit on how large these savings can get except as noted above.
 - *Rainy Day Savings:* These are savings for expected costs that might arise. These savings cannot exceed 100% of the participant's monthly allocation

FC FACTS

- Consultant services provided by Transition II.
- Consumer or Surrogate Employer must be certified by the consultant.
- Case Management Services are not automatically provided but may be purchased in the budget.
- Employer and Employees must enroll with payroll agency (ARIS).
- All services paid via payroll agent ARIS.
- Allowance based on assessment and worksheet.
- Budget for services is based on an allowance and determined by individual with help from consultant.
- Budget is more flexible than “traditional” home-based services.

Program for All Inclusive Care for the Elderly (PACE)

Definition: Program for All-inclusive care for the Elderly (PACE) are pre-paid, capitated programs for Medicare only, Medicare and Medicaid and private pay individuals who elect to enroll. The purpose of the PACE program is to provide pre-paid, capitated, comprehensive health care services.

The PACE benefit package includes for all participants:

- all Medicaid covered services as specified in the State's approved Medicaid plan,
- all Medicare services, and
- all services deemed necessary by the interdisciplinary team.

***PACE is offered in only two areas of the state:
Chittenden/Parts of Grand Isle and Rutland***

PACE Eligibility

To be eligible for PACE, an individual must:

- Be at least 55 years old.
- Live in one of the following areas:
 - Chittenden County
 - Rutland County
 - Southern Grand Isle County (South Hero, Grand Isle),
- Meet clinical eligibility criteria for nursing facility level of care.
- Be certified eligible for long-term care Medicaid by the Department for Children and Families or be able to privately pay.
- Be able to live safely in the community with services from PACE.

PACE Services

PACE Benefit package:

1. Interdisciplinary team assessment and treatment planning
2. Primary care services including physician and nursing services;
3. Social work services;
4. Restorative therapies, including physical therapy, occupational therapy and speech-language pathology;
5. Personal care and supportive services;
6. Nutritional counseling;
7. Recreational therapy;
8. Transportation;

PACE Services

PACE Benefit package (cont.):

9. Meals;
10. Medical specialty services including but not limited to: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhinolaryngology, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology surgery, thoracic and vascular surgery, and urology
11. Laboratory tests, x-rays and other diagnostic procedures
12. Drugs and biologicals
13. Prosthetics and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items

PACE Services

Benefit package (cont.):

14. Acute inpatient care: ambulance; emergency room care and treatment room services; semi-private room and board; general medical and nursing services; medical surgical/intensive care/coronary care unit, as necessary; laboratory tests, x-rays and other diagnostic procedures; drugs and biologicals; blood and blood derivatives; surgical care, including the use of anesthesia; use of oxygen; physical, occupational, and respiratory therapies; speech-language pathology; and social services.
15. Nursing facility care: semi-private room and board: physician and skilled nursing services; custodial care; personal care and assistance; drugs and biologicals; physical, occupational, and recreational therapies and speech-language pathology, if necessary; social services; and medical supplies and appliances.

PACE FACTS

- Effective start date is always the first of the month following financial eligibility if determined is in the DCF ACCESS system by the 25th.
- PACE dual=\$4,017/mo, PACE Medicaid only=\$5,205/mo.
- Payment to PACE is an automatic each month for each person enrolled.
- PACE uses the "Core Outcome and Comprehensive Assessment" (COCO) assessment tool. (federally required)

What Have You Learned So Far?

(True/False)

1. All CFC participants are eligible to Consumer Direct their care.
2. Skilled Nursing is a Choices for Care service in the home-based setting.
3. PACE must pay for all necessary medical services, including a heart transplant.
4. ERC Providers provide nursing overview and assessment.
5. In Flexible Choices participants are allowed spending money.
6. Individuals with high medical needs must get their services in a Nursing Facility.
7. People with a cognitive impairment must choose an ERC or NF for their service setting.
8. In the home-based setting respite care is limited to 720 hours a calendar year.
9. A case manager may only report suspected abuse to APS if the individual gives them permission to do so.
10. Case Managers are only responsible for arranging Choices for Care services.

Answers

1. All CFC participants are eligible to Consumer Direct their care. **False**
2. Skilled Nursing is a Choices for Care service in the home-based setting. **False**
3. PACE must pay for all necessary medical services, including a heart transplant. **True**
4. ERC Providers provide nursing overview and assessment. **True**
5. In Flexible Choices participants are allowed spending money. **True**
6. Individuals with high medical needs must get their services in a Nursing Facility. **False**
7. People with a cognitive impairment must choose an ERC or NF for their service setting. **False**
8. In the home-based setting respite care is limited to 720 hours a calendar year. **True**
9. A case manager may only report suspected abuse to APS if the individual gives them permission to do so. **False**
10. Case Managers are only responsible for arranging Choices for Care services. **False**

CFC 101 TRAINING

DAY 2

- I. Application Process
- II. Assessments & ILA
- III. Service Plan Development
- IV. Change of Setting
- V. Quality Assurance
- VI. Waiver Teams
- VII. Other Resources

Application Process

***Turn to Tab 6 in Binder for the Choices for Care Program Application form CFC 801.
Turn to Tab 2 in binder to “Application Process At-A-Glance”***

- CFC Application sent to LTCCC.
- LTCCC contacts individual within 3 working days.
- Face-to-face assessment and options education completed by LTCCC.
- Clinical eligibility determined by LTCCC.
- Clinical Certification sent to DCF and case management provider or nursing facility.
- Case manager completes assessment & service plan within 14 working days.
- DCF determines financial eligibility.
- LTCCC reviews and approves Service Plan.
- Services start.

Assessments

- **Independent Living Assessment (ILA)**: Home-Based setting, completed by the case manager and RN (health assessment).
- **Comprehensive Resident Assessment (CRA)**: Residential Care Home, Assisted Living Residence setting, completed by the provider.
- **Minimum Data Set (MDS)**: Nursing Facility setting, completed by the provider.
- **Core Outcome and Comprehensive Assessment (COCO A)**: Used by PACE provider. Federally required.

ILA Timeframes

- **Initial Assessment**: Entire ILA completed within 14 days of receipt of the Clinical Certification.
- **Annual Reassessment**: Entire ILA completed 4-6 weeks prior to the Service Plan end date, at least once a year. Submit to LTCCC approx. 2 weeks prior to Service Plan end date.
- **Change**: Completed when the individual has a change in need prior to the annual reassessment. Only applicable parts of ILA are completed.

Complete Packets

● Initial Assessment

- Entire ILA or CRA (completed by provider)
- Permission to Release Information
- Service Plan with signatures
- Personal Care Worksheet (HB) or Tier Worksheet (ERC)
- Employer Certification (CD/SD only)
- Variance Requests (if applicable)
- Assistive Device/Home Mod form (if applicable)
- Live-in care Agreement (if applicable)

*****Incomplete packets may be returned.***

Complete Packets (cont.)

- **Annual Reassessment**

- Entire ILA or CRA
- Permission to Release Information
- Service Plan with signatures
- Personal Care Worksheet (HB) or Tier Worksheet (ERC)
- Employer Certification (CD/SD only)
- Variance Requests (if applicable)
- Assistive Device/Home Mod form (if applicable)

*****Incomplete packets may be returned.***

Complete Packets (cont.)

● Changes

- Parts of ILA or CRA that pertain to the change
- Personal Care Worksheet or Tier Worksheet (if change in hours or tier rate)
- Service Plan with signatures
- Assistive Device/Home Mod form if applicable
- Employer Certification if changing to CD/SD
- Variance request if applicable

Other Plans

- **Emergency Contact and Backup Plan:** Complete with the individual and family. Leave in a conspicuous place in home. Update as needed. Do not send to LTCCC.
- **Action Plan:** Complete with the individual at initial assessment, updated at reassessment and as needed. Addresses issues and goals, plan/strategy, the responsible person for each task and the target date for each issue and goal. Copy to individual and case manager. See Case Management Standards for more information. Do not send to LTCCC.
- **Agreement for Live-in Care:** Room and board agreement for care in the home of an unrelated caregiver. Required for CFC home-based care.

Cognition Assessment

Go to Tab 5 “Tips for Assessing Cognitive Skills for Decision Making”

Cognitive Skills for Daily Decision Making

● **Intent:** To record the individual’s actual performance in making everyday decisions about tasks or activities of daily living in the last 7 days.

● **KEY:**

- **Independent** – The individual’s decisions in organizing daily routine and making decision were consistent, reasonable and organized reflecting lifestyle, culture and values.
- **Modified independence** – The individual organized daily routine and made safe decisions in familiar situations but experienced some difficulty in decision making when faced with new tasks or situations. Occasionally needed help.
- **Moderately impaired** – The individual’s decisions were poor: the individual required reminders, cues, and supervision in planning, organizing, carrying out daily routines. The individual may have attempted to make decisions, although poorly. Occasionally participated in decisions and carried out daily routine. Required significant help.
- **Severely impaired** – The individual’s decision making was severely impaired: the individual never (or rarely) participated in planning, organizing or carrying out their daily routine (despite being provided with opportunities and appropriate cues). Total help was needed.

Functional Assessment – ADLs

Go to Tab 5 “*ILA Functional Assessment Keys*” and “*Functional Assessment Tips*”

Activities of Daily Living (ADL)

- **Intent:** To measure the individual’s ability to perform ADL’s in the last 7 days.
- **ADL Self-Performance KEY:**
 - **0 = Independent** – No help or oversight –OR- help/oversight provided only 1 or 2 times during the last seven days.
 - **1 = Supervision** – Oversight, encouragement or cueing provided 3 or more times—OR— Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.
 - **2 = Limited Assistance** – Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times—OR—Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last 7 days.
 - **3 = Extensive Assistance** – While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.
 - **4 = Total Dependence** –Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a “4” Total Dependence.
 - **8 = Activity did not occur in the last 7 days** –OR – Unknown – If the activity did not occur at all in the last seven days, or the Self-Performance of the individual is unknown, score an “8”.

Functional Assessment- ADLs (cont.)

- **Bathing KEY:** Due to the nature and frequency of the bathing activity, the following self-performance scale is used. NOTE: Exclude back and hair in the measurement of bathing ability.
 - **0 = Independent** – No help or oversight provided.
 - **1 = Supervision** – Oversight, encouragement or cueing only.
 - **2 = Limited Assistance** – Individual highly involved in activity, received physical help to transfer only.
 - **3 = Extensive Assistance** – While individual performed part of activity, physical help in part of the activity was provided.
 - **4 = Total Dependence** – Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a “4” Total Dependence.
 - **8 = Activity did not occur in the last 7 days –OR – Unknown** – If the activity did not occur at all in the last seven days, or the Self-Performance of the individual is unknown, score an “8”.

Functional Assessment- ADLs (cont.)

- **Support Provided** is the type and amount of support provided by another paid or unpaid person in the last 7 days.
- **KEY:**
 - 0 - No setup or physical help
 - 1 - Setup help only
 - 2 - One person physical assist
 - 3 - Two+ persons physical assist
 - 8 - Activity did not occur during entire 7 days –**OR-** Unknown

Functional Assessment- IADLs

Instrumental Activities of Daily Living (IADL)

- **Intent:** To measure the individual's ability to perform IADL's in the last 7 days.
- **IADL Self-Performance KEY:**
 - **0 = Independent** – The individual received no help at all from another person in performing IADL's in the last seven days.
 - **1 = Done with Help** – The individual was involved in the activity but received some help including supervision, reminders, and/or physical help in the last seven days.
 - **2 = Done by Others** – The individual was not involved at all in performing the IADL in the last seven days. The activity was performed completely by another person.
 - **8 = Activity did not occur in the last 7 days** – If the activity did not occur at all in the last seven days, score an "8". If the individual needed help, but did not receive any in the last seven days, note this in the *Comments* space as an unmet need.

Functional Assessment- IADLs (cont.)

- **Support Provided** is the type and amount of support provided by another paid or unpaid person in the last 7 days.
- **KEY:**
 - 0 – No support provided
 - 1 – Supervision/Cueing only
 - 2 – Setup only
 - 3 – Physical assistance provided
 - 8 – Activity did not occur (as defined) in last 7 days –OR- Unknown

Important Things to Consider Before Creating a Service Plan

Go to Tab 8 in binder for policies

- CD/SD Employer Certification
- Hospice policy
- Live-in care arrangements
- Paying spouses
- Non-CFC services
- Variance Requests

Personal Care Worksheet

Go to Tab 6 “Personal Care Worksheet”

A Personal Care Worksheet is completed after the ILA functional assessment and is required for the Choices for Care (CFC) Home-Based setting under the following circumstances:

- Initial assessments
- Reassessments
- Change in personal care services

Variance Requests

A **Variance Request** must include:

- a description of the individual's specific unmet need/s,
- why the unmet need can not be met with other services, e.g. LNA, Adult Day, Respite, Companion, and
- the actual/immediate risk posed to the individual's health and welfare by the unmet need

Go to Tab 6 HB Service Plan

Service Plans

Go to Tab 6 for Service Plans

- Service Plan must be complete, including signatures.
- ICD9 Codes - required for ALL Medicaid billing
- Providers can not bill without an approved Service Plan.
- Individual/legal rep. and case manager must sign. (consider who is legal rep)
- ERC provider must also sign the ERC Service Plan.

NOTE: Service Plans may be returned if incomplete.

Service Plan Start Dates

Start Dates:

- **Initial:** Latest of the following:
 - Date of application date, or
 - Date off wait list (if applicable), or
 - Date of Long-Term Care Medicaid eligible (Per DCF/ESD)
- **Reassessment:** The day after the previous Service Plan expired.
- **Changes:** No earlier than the date the Service Plan is received at the DAIL regional office.
- **Consumer/Surrogate Changes:** No earlier than the start of the next payroll period after the Service Plan is received at the DAIL regional office.
- **Retroactive Start Dates:** NOT automatic. Must request each time and identify the reason why.

Practice

- Review the practice ILA.
- Complete a Personal Care Worksheet.
- Complete a Home-Based Service Plan.
- Discussion.

ERC Tier Worksheet

Go to Tab 5 & 6 to *CRA & ERC Tier Worksheet & Service Plan*

- Obtain a current CRA from the provider.
- Review information for accuracy.
- Complete Tier Worksheet using CRA.
- Submit with Service Plan packet to LTCCC.

Practice

- Review the practice CRA.
- Complete an ERC Tier Worksheet.
- Complete an ERC Service Plan.
- Discussion.

Utilization Review

- **“Utilization Review” (UR)** is a Department of Disabilities, Aging and Independent Living (DAIL) review process intended to assure that the Choices for Care (CFC) service type and volume are appropriate to meet the needs of eligible individuals in an efficient and effective manner.

Utilization Review (cont.)

DAIL staff shall consider variables such as, but not limited to:

- Health status of the individual
- Functional needs of the individual
- Total number of people living in the individual's household
- Size of the living environment
- Utilization of other CFC services (such as adult day in the home-based setting)
- Utilization of non-CFC services, including paid and unpaid help (such as Medicare home health services or family)
- Variance requests submitted by the case manager

Practice

- Review the practice ILA and attached documentation.
- Review the Personal Care Worksheet.
- Document areas of duplication, error, or questions.
- What follow-up or changes would you recommend?
- Discussion.

Case Management Monitoring

- **Home-Based**: Case manager must complete and document face-to-face visits no less than once every 30 days. Must be in the home at least once every 60 days.
- **ERC**: Case manager must complete and document contact with the individual every 30 days, and face-to-face visit at least every 60 days. Contact with the home provider required once every 60 days.

NOTE: Monitoring visits must address all areas of need, not just CFC services.

Change of Setting

Go to Tab 6

- **Home-based & ERC Change Form:** Completed by Case Manager for admissions to nursing facility. Must send to LTCCC, DCF and NF within 10 days of the change.
- **Nursing Home Discharge Form:** Completed by nursing facility. Must send to LTCCC and DCF within 10 days of the change. Nursing facility must notify appropriate case management agency.

NOTE: Change notices are critical for proper payment of claims.

Terminations

- **Change Form**: Must be completed by case manager and sent to LTCCC, DCF and providers.
 - Death
 - Permanent move out of state
 - Temporary stay out of state exceeding 30 continuous days
 - The individual no longer requires Choices for Care services (condition has improved or other services meeting their needs)
- **Voluntary Withdrawal**: Individuals must sign the form.
- **Involuntary Termination**: Must receive notice with appeal rights. (clinical or financial ineligibility) Includes provider termination if 30-days non-use of services.

Appeals

- **Notice**: Any adverse action by the State (DAIL/DCF) must be in writing to the individual with appeal rights. Legal aid number included on the notice.
- **Appeal Rights**: Can appeal with or without a lawyer.
 - Commissioner Hearing (within 30 days of receipt of notice), or
 - Human Services Board (within 90 days of receipt of notice)
- **Continued Services**: Not all appeals qualify for “continued services”. Follow instructions on notice.
- **Ombudsman**: If needed, Ombudsman can help with appeal.
- **Timeframes**: Very important to follow timeframes on the appeal rights notice.

NOTE: Contact DAIL legal services with any questions regarding appeals at 241-2401.

Quality Assurance

Many levels of Quality Assurance:

- Case Management Monitoring
- DDAS Quality Management Unit
- Division of Licensing and Protection
- DAIL Macro Survey
- Legal Aid
- Medicaid Fraud Unit
- Provider QA Activities
- Ombudsman

DDAS Quality Management Plan

- Managed by the DDAS Quality Management Unit
- Review of DDAS Waiver programs
- Based on CMS Quality Framework
- Two year review cycle
- The purpose is to provide:
 1. Processes for information gathering, remediation, and improvement activities;
 2. Indicators and standards against which performance is measured; and
 3. A cohesive and focused work plan that directs time, effort, and resources.

NOTE: Refer to DDAS website

<http://www.ddas.vermont.gov/ddas-units/units-quality-management-default-page>

Desired Outcomes

Quality Management Plan, Desired Outcomes:

1. **Respect**: Individuals are treated with dignity and respect.
2. **Self-Determination**: Individuals direct their own lives.
3. **Independent Living**: Services support independent living.
4. **Relationships**: Individuals receive support to foster and maintain relationships.
5. **Participation**: Individuals participate in their local communities.
6. **Person-Centered Practices**: Services and supports are individualized to meet people's needs and honor their strengths and preferences.
7. **Well-being**: Individuals' services and supports promote health and well-being.
8. **Communication**: Individuals communicate effectively with others.
9. **Collaboration**: Individuals receive effective, coordinated, and efficient services.
10. **Support Systems**: Individuals benefit from a trained and competent support system.

Waiver Teams

- Choices for Care multi-disciplinary team
- Meet monthly
- Facilitated by LTCCC
- Trouble-shoot difficult cases
- Discuss successes
- Brainstorm ideas
- Education and program updates

Other Resources

- Assistive Community Care Services
- Assistive Technology
- Attendant Services Program
- Children's Personal Care
- Community Rehab and Treatment
- Dementia Respite Program
- Developmental Services Program
- Flexible Funds
- High-Tech Services
- Home Health Services
- Moderate Needs Services
- Traumatic Brain Injury Program

NOTE: Refer to DAIL Website at <http://www.dail.vermont.gov/>

What have you learned so far?

(True or False)

1. The Initial Assessment and Service Plan must be completed within 4 weeks of receipt of the Clinical Certification.
2. The Annual Reassessment must be completed 4-6 week prior to the Service Plan end date.
3. Providers may continue to bill for services after a Service Plan has expired.
4. The Functional Assessment is intended to be used to score the amount of personal care hours desired?
5. The Personal Care Worksheet contains the maximum amount of personal care time paid by Choices for Care for ADLs and IADLs.
6. Variances will be granted any time a person really wants more time for personal care.
7. ERC Tiers are based on the assessed need using the ILA tool.
8. ERC Tiers are only used in Licensed III Residential Care homes.
9. Individuals will be terminated from Choices for Care when they leave the state for more than 30 consecutive days.
10. For individuals at home, the case manager must complete a face to face visit every 90 days.
11. The effective start date of a consumer/surrogate Service Plan is the first day of the payroll cycle after the Service Plan is received by the LTCCC.

Answers

1. The Initial Assessment and Service Plan must be completed within 4 weeks of receipt of the Clinical Certification. **False**
2. The Annual Reassessment must be completed 4-6 week prior to the Service Plan end date. **True**
3. Providers may continue to bill for services after a Service Plan has expired. **False**
4. The Functional Assessment should be completed based on the amount of personal care hours desired by the individual? **False**
5. The Personal Care Worksheet contains the maximum amount of personal care time paid by Choices for Care for ADLs and IADLs. **True**
6. Variances will be granted any time a person really wants more time for personal care. **False**
7. ERC Tiers are based on the assessed need using the ILA tool. **False**
8. ERC Tiers are only used in Licensed III Residential Care homes. **False**
9. Individuals will be terminated from Choices for Care when they leave the state for more than 30 consecutive days. **True**
10. For individuals at home, the case manager must complete a face to face visit every 90 days. **False**
11. The effective start date of a consumer/surrogate Service Plan is the first day of the payroll cycle after the Service Plan is received by the LTCCC. **True**

The End - Thank you!

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<http://www.ddas.vermont.gov/>