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** Appendices*

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Appendix E: Letters of Endorsement

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--State of Vermont Department of Mental Health

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Appendix F: Choices for Care Emergency Contacts and Back-up Plan

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**Note that the Vermont MFP Appendices are all located in a separate appendices file with a corresponding table of contents.*

A. PROJECT INTRODUCTION

A.1 Organization and Administration

Part #1 - Systems Assessment and Gap Analysis

1. A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives that have affected the system. What State legislative and/or regulatory changes need to be made to further rebalance the LTC system and promote HCBS?

Introduction

The state of Vermont has been a leader in promoting person-centered services for individuals in need of long-term care. In 2005, Vermont collaborated with CMS in development of Choices for Care, the state's groundbreaking Section 1115 long-term care research and demonstration waiver program.

One of the primary goals of Choices for Care is to provide participants with equal access to long-term care options in community and institutional settings, while preventing unnecessary use of nursing facility care by elders and adults with disabilities who have functional impairments. Vermont has made significant progress toward achieving this goal. In State Fiscal Year (SFY) 2010, approximately 60 percent of older adult beneficiaries and person with disabilities were served in home and community settings, up from only 34 percent in SFY 2006.

Vermont's progress over the past five years has positioned the state to focus on one of the most challenging groups within Choices for Care: longer stay nursing facility residents who desire to return home or to another community alternative. Although many former nursing facility residents have returned to the community under Choices for Care, there are longer stay

residents throughout the state who face barriers to discharge related to lack of initial transition supports and other services necessary to address their complex needs.

Vermont's Money Follows the Person (MFP) demonstration application is targeted at removing these barriers. Upon approval of Vermont's operational protocol, the state will embark on a variety of new rebalancing initiatives intended to complement Choices for Care, and ultimately expand service and placement options for all waiver-eligible persons.

Current Long-Term Care Support Systems

Vermont's current long-term care support systems are described below. The support systems for all long term care populations are described, beginning with older adults and persons with physical disabilities (addressed as one group) and finishing with a discussion of systems serving persons with mental health needs and persons with intellectual disabilities. Section 1 of the application concludes with a review of legislative and regulatory requirements for the demonstration.

Older adults/Persons with Physical Disabilities - Vermont's long-term care population, including older adults and persons with physical disabilities, is served through the Choices for Care waiver. Participants are offered three program options: Home-Based Supports, Enhanced Residential Care and nursing facility care. Home-Based Supports, in turn, has five distinct alternatives: agency directed care, consumer directed care, surrogate directed care, Flexible

Choices and PACE. Consumer and surrogate directed care are both employer-authority options while Flexible Choices is a budget-authority option.

Individuals in home- and community-based placements receive services in accordance with person-centered care plans. MFP demonstration participants will be enrolled in Choices for Care and will have available the same menu of qualified HCBS services, including case management, personal care, respite care, companion care, adult day services, assistive devices, home modifications and personal emergency response systems.

Mental Health - Mental (behavioral) health services are provided through private, non-profit community mental health centers, known in Vermont as Designated Agencies (DA's). Each DA has a defined geographic jurisdiction within which it is responsible for ensuring needed services are available. The programs offered through the DA's include Community Rehabilitation and Treatment for persons with serious mental illnesses, Adult Outpatient and Emergency/Crisis services. The DA's are responsible for providing behavioral health services to Choices for Care enrollees living at home or another community setting.

Persons with Intellectual Disabilities - All Vermonters with intellectual disabilities are served in community settings. Supports are provided by private non-profit developmental disability service providers throughout the state. Individuals or their families may also choose to self- or family-manage their own services with the assistance of an Intermediary Service Organization.

Legislative and Regulatory Changes

There are no legislative actions required to implement the MFP demonstration or offer any of the new services described below. Adult Family Care, which would be a new Qualified HCBS service, already is authorized in statute.

Vermont also does not believe that an amendment to the Choices for Care waiver will be required to implement any portion of the MFP demonstration. However, the state will consult with CMS immediately upon grant award to verify this is correct. If an amendment is deemed necessary, the state will submit the amendment within 30 days and will work closely with CMS to complete the amendment process. In the interim, DAIL will proceed to implement as much of the demonstration as can be accomplished under the existing waiver, including hiring of staff and contracting with providers in anticipation of the go live date.

Job descriptions for the new positions identified below will have to be created and regulations will have to be promulgated for the new benefits proposed under the demonstration. DAIL will commence both activities upon grant award to ensure timely implementation.

2. An assessment of what Medicaid programs and services are working together to rebalance the State's resources and a description of any institutional diversion and/or transitions programs or processes that are currently in operation. What additional Medicaid programs and services are needed to increase HCBS and decrease the use of institutional care?

Current programs and services

Vermont residents currently transitioning from a hospital or nursing facility to the community receive outreach first from a hospital or nursing facility discharge planner. They also can be

referred from a residential setting by family members, caregivers, guardians, local Aging and Disability Resource Centers (ADRCs) and advocates. Once referred, the resident must meet financial and clinical criteria to be found eligible.

Choices for Care case managers are responsible for working with nursing facility discharge planners to plan and carry out the transition back to the community. Although this process works relatively well for residents with less complex needs, it is not ideal for individuals with complex needs. There is no formal program (infrastructure) in place for transition and placement of complex, longer-stay residents.

Additional Medicaid Programs and Services needed to Increase HCBS

During the summer and fall of 2010, DAIL representatives met with private and public stakeholders throughout the state to document barriers to discharge for longer stay nursing facility residents. In addition to an enhanced transition infrastructure and process, stakeholders identified the need for one-time financial assistance to cover expenses associated with relocating to the community; service settings that include 24-hour supervision; and appropriate supports for persons with behavioral health needs. The proposed supports and services are delineated below.

Transition Coordinators – Vermont will create the position of Transition Coordinator, to be located within DAIL and devoted to the MFP demonstration. Transition Coordinators will be responsible for doing all of the following:

- Making visits to nursing facilities across the state to screen and identify individuals eligible for the MFP demonstration;
- Responding to MFP referrals from nursing facilities, residents (self-referrals), families, guardians and others; undertaking comprehensive transition planning at least 90 days prior to discharge;
- Performing transition assessments (including a comprehensive risk assessment);
- Developing individualized plans of care in collaboration with the participant and the participant's assigned case manager;
- Collaborating with the participant's case manager and Community Development Specialist (described below) to arrange and coordinate services pre-transition;
- Performing discharge planning functions in coordination with the nursing facility; and carrying out post-transition follow-up calls and visits as necessary to ensure implementation of the plan-of-care and to identify any unmet needs that could pose a risk of re-institutionalization.

The state also will contract with organizations having special expertise in addressing the needs of transitioning members, such as the Center for Independent Living, Area Agencies on Aging, HomeShare Vermont and the Designated Agencies, to serve as consultants to the transition teams. Representatives of the organizations will be available as a resource on a case-by-case basis, as well as to advise the state on broader transition strategies.

Community Development Specialists – Every demonstration participant, through their Transition Coordinator, will have access to a Community Development Specialist responsible for identifying appropriate housing alternatives and linking participants to other community support services, such as transportation. In addition to their participant-specific activities, Community Development Specialists, who will be contracted staff, will work to increase total alternative housing capacity. They also will conduct extensive marketing and outreach activities and provide training on program eligibility requirements and policies and procedures to MFP staff, HCBS providers and nursing facilities.

Transition Payment – To assist individuals in defraying transition costs not covered through other waiver services, a one-time set-up payment of up to \$2,500 will be provided. Transition payments will be furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. Transition payments will be used to pay for a variety of items and services, including but not limited to: security deposits, home access modifications, utility deposits, pest eradication, household goods, household setup and food stocking.

Adult Family Care - Adult Family Care consists of an adult home established and operated for the purpose of providing long-term residential care (room, board, housekeeping, personal care, and supervision) in an environment that is safe, family oriented, and designed to maintain a high level of independence and dignity for the resident. Adult Family Care will be an addition to the current menu of Qualified HCBS available under Choices for Care. Adult Family Care will

resolve a barrier to transition that currently exists by enabling more participants who require 24-hour supervision to move to a community setting. Homes will serve one to two residents.

Mental Health Programs – A portion of the nursing facility population to be transitioned under the demonstration have both behavioral and physical health needs. DAIL, the Department of Mental Health (DMH), the Designated Agencies, Area Agencies on Aging and other stakeholders will collaborate in developing long-term strategies to ensure availability of appropriate support services. One approach under consideration would be to create a “behavioral health specialist” certification for Adult Family Care home providers who complete necessary training, and to pay these providers a higher rate.

3. A description of the number of potential participants who are now living in institutions including the number of residents in nursing homes who have indicated they would like to transition into the community.

DAIL undertook a feasibility analysis in the summer and fall of 2010 to evaluate the potential size of the MFP-eligible population. The analysis was conducted through onsite interviews with administrators and discharge planners at nursing facilities located throughout the state.

Exhibit 1 below identifies the number of MFP-eligible residents, segmented into the CMS defined populations. The facilities visited during the feasibility analysis contained 39 eligible residents and, coincidentally, represented 39 percent of the total Medicaid nursing home population, resulting in a statewide estimate of 100. The 2011 figure is projected to increase by five residents per year, based on historical growth rates and consultation with stakeholders.

Exhibit 1 – Estimate of MFP-Eligible Nursing Facility Residents by Category

Calendar Year	Older adults	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total
CY 2011	86	-	14	-	-	100
CY 2012	90	-	15	-	-	105
CY 2013	94	-	16	-	-	110
CY 2014	98	-	17	-	-	115
CY 2015	102	-	18	-	-	120
CY 2016	106	-	19	-	-	125

4. A description of any current efforts to provide individuals with opportunities to self-direct their services and supports. Would your State be developing additional opportunities for participants to self-direct?

Choices for Care offers three options to individuals who wish to self-direct their services and supports: consumer directed, surrogate directed and the Flexible Choices Program. In the home-based setting, Choices for Care offers three services that may be directed by the individual or a surrogate employer: personal care, respite care and companion services.

If an individual who is participating in Choices for Care is able and willing to be an employer for their own personal care, respite or companion services, they may apply for the consumer-directed option. However, if the individual is not able or willing to be the employer, a trusted friend or family member may apply to be the surrogate-directed employer.

The Flexible Choices option within Choices for Care is based on the belief that consumers and their families know best how to meet the needs of individuals residing at home. Flexible

Choices offers consumers an allowance, which is based on their needs and the value of their Choices for Care home-based service plan.

MFP demonstration participants will be afforded the same options to self-direct their services as other Choices for Care enrollees. MFP participants will be counseled by the Transition Coordinator at the time of enrollment about the three self-direction options. As in the current program, case managers will be responsible for training and assisting individuals to understand the obligations and procedures of self-direction. An employer handbook has been developed for Choices for Care and will be distributed to all MFP participants who wish to self-direct. A copy of the handbook is included in Appendix A of the application.

5. Describe the stakeholder involvement in your LTC system. How will you include consumers and families as well as other stakeholders in the implementation of the MFP demonstration?

Vermont involves both private and public stakeholders in oversight and evaluation of the Choices for Care program. The state contracts with the University of Massachusetts to conduct an independent evaluation of the program, including documenting stakeholder perceptions through surveys and other primary research.

The state also involves consumers through the Department Aging and Independent Living Advisory Board. The Board's composition and duties are described in greater detail in Section B.4 of the application. Consumers, families and other stakeholders will be consulted on the implementation of the MFP demonstration through both the DAIL Advisory Board and an ad hoc committee of stakeholders also described in Section B.4.

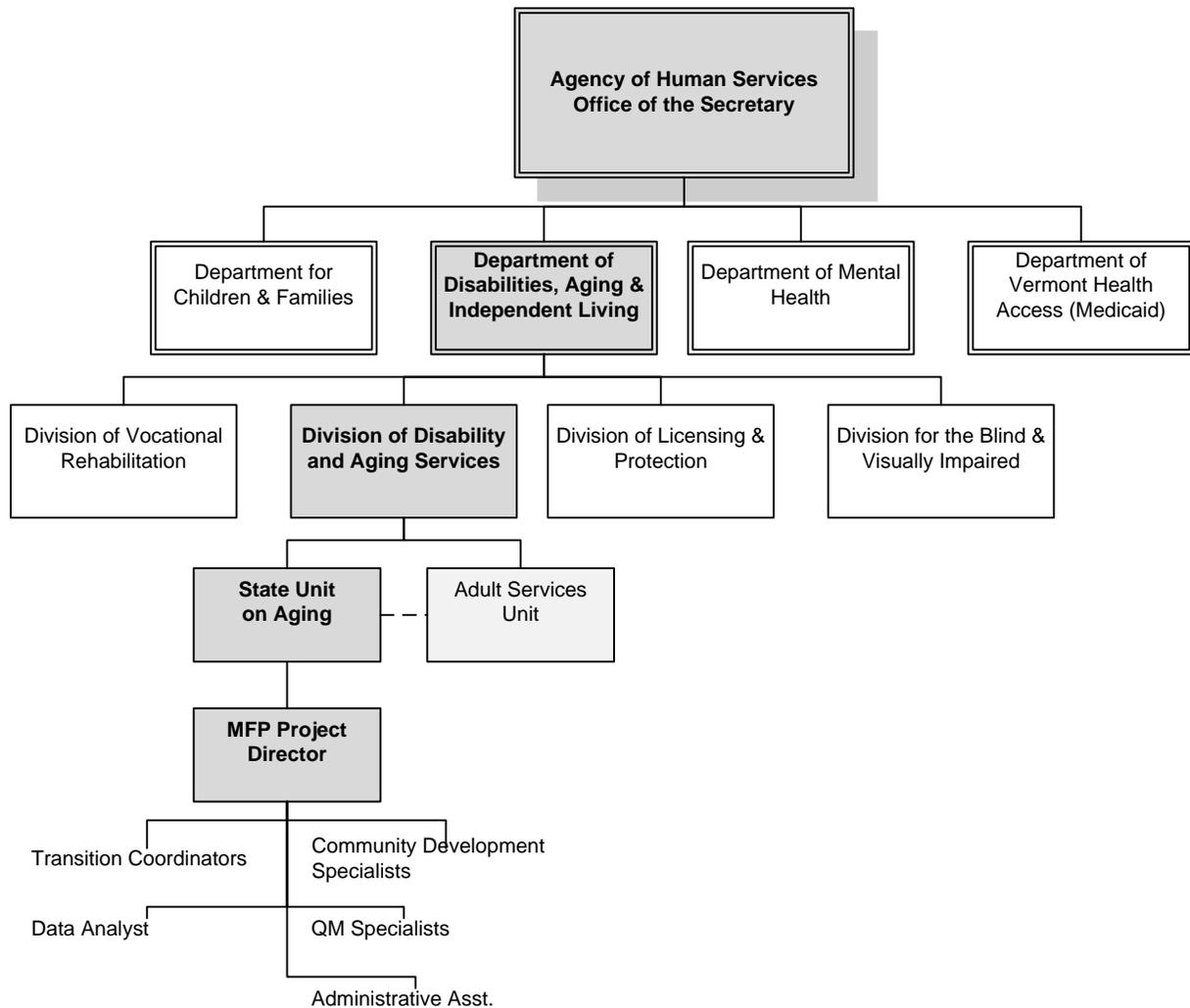
Part #2

Description of the Demonstration’s Administrative Structure

Describe the Administrative structure that will oversee the demonstration. Include the oversight of the Medicaid Director, which agency will be the lead agency, all departments and services that will partner together, the administrative support agencies that will provide data and finance support and what formal linkages will be made and by what method, (i.e. Memorandum of Agreement, reorganization).

Exhibit 2 below presents an organizational chart depicting the relationships among the various partners who will be involved in the demonstration.

Exhibit 2 – Administrative Structure for Vermont’s MFP demonstration



The Agency of Human Services (AHS) is the single state agency for Medicaid in Vermont, and has the overall responsibility for the MFP demonstration program. The Department of Vermont Health Access (DVHA) within AHS is responsible for administration of the Medicaid program and is headed by the Medicaid Commissioner.

The Department of Disabilities, Aging, and Independent Living (DAIL) will be the lead agency for the MFP demonstration within AHS. Camille George, Director, State Unit on Aging, will act as the interim Project Director until a permanent director is hired. The search for a permanent director will commence upon grant award.

In addition to the Project Director, the MFP component of DAIL will house Transition Coordinators, Community Development Specialists (contracted staff), QM Specialists, a Data Analyst and an Administrative Assistant.

As previously described, DAIL also will contract with organizations that do not act as direct service providers to serve as consultants to Transition Coordinators. These will likely include a combination of the Vermont Center for Independent Living, Area Agencies on Aging, Designated Agencies, State Independent Living Council, HomeShare Vermont and other local organizations familiar with Vermont's supportive home- and community-based services.

Partnering agencies will include the Department of Vermont Health Access (DVHA), Department of Mental Health (DMH) and Department for Children and Families (DCF). DVHA and DMH have

been involved in the design and development of the demonstration model and will continue to play an active role as it is implemented. DCF is responsible for performing financial eligibility determinations for Choices for Care participants. Because all of the departments reside within AHS, no memorandum of understanding or other intergovernmental agreement will be necessary to codify their responsibilities.

Operational and financial data reporting activities will be performed by the MFP Data Analyst hired for this purpose through the demonstration. This individual will coordinate financial reporting on the CMS-64 with AHS Business Office. As the state office responsible for the management of Medicaid and other publicly funded health insurance programs in Vermont, DVHA also will be instrumental in assisting with cost avoidance activities.

A.2 Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. In the application, two specific benchmarks were required by all awardees. These two benchmarks are:

- *Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.*
- *Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.*

To assess Vermont's progress in transitioning individuals to the community and rebalancing its long-term care system, the state will measure the progress of five benchmarks on an annual basis. Each calendar year, we will collect data for two benchmarks required by CMS and for three benchmarks proposed by Vermont. The two required benchmarks follow.

Benchmark 1 – (Required) Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration

Exhibit 3 below presents the projected numbers of MFP-eligible individuals (by target population group) who will be assisted to transition to qualified residences in each calendar year of the demonstration. The projection is based on a target transition rate equal to approximately 50 percent of eligible nursing facility residents in year one, increasing to 60 percent by year five. The state recognizes these are aggressive targets but believes they can be achieved by building on the success of the Choices for Care waiver.

A total of 50 residents are expected to transition from nursing facilities in Year 1, and a grand total of 375 unduplicated individuals will transition throughout the demonstration period.

Exhibit 3 – MFP-Eligible Residents by Target Group by Calendar Year

Calendar Year	Older adults	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total
CY 2011	43	-	7	-	-	50
CY 2012	47	-	8	-	-	55
CY 2013	52	-	8	-	-	60
CY 2014	56	-	9	-	-	65
CY 2015	60	-	10	-	-	70
CY 2016	65	-	10	-	-	75

Benchmark 2 – (Required) Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program

Exhibit 4 below presents the projected increase in Medicaid support (spending) for home- and community-based long term-care services (all long-term care, not only MFP spending) for each calendar year of the demonstration. The expenditure projections include both state and federal dollars and represent an annual trend rate of two percent.

Exhibit 4 – Increase in Medicaid Expenditures for HCBS

Calendar Year	HCBS Expenditures
CY 2011	\$56,890,315
CY 2012	\$58,028,121
CY 2013	\$59,188,684
CY 2014	\$60,372,457
CY 2015	\$61,579,906
CY 2016	\$62,811,505

Vermont proposes the following three additional success benchmarks to measure performance under the demonstration.

Benchmark 3 – Increase in the number of participants that secure community housing through the Community Development Specialist each year.

Exhibit 5 below projects the number of individuals who will secure a qualified residence option with the assistance of DAIL’s Community Development Specialists in each calendar year of the demonstration. The Specialists will play an important role in expanding placement options for MFP demonstration participants and their effectiveness will be evaluated at both the individual level and in aggregate.

The state projects that approximately one-third of all participants will receive assistance from this critical resource, which is being added specifically for the MFP demonstration.

Exhibit 5 - Participants Who Secure Housing through the Community Development Specialist

Calendar Year	Total Transitioning Residents	Residents Securing Housing with Assistance from CD Specialist
CY 2011	50	17
CY 2012	55	18
CY 2013	60	20
CY 2014	65	22
CY 2015	70	23
CY 2016	75	25

Benchmark 4 - Increase in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program and who receive a transition packet each year.

This benchmark measures the number of Medicaid-eligible nursing facility residents who will be informed of the MFP demonstration and receive a transition packet each year. Vermont believes the Transition Coordinator will play an essential role in generating awareness of the demonstration among nursing facility residents and their families. The distribution of transition packets will be a reliable benchmark for measuring the productivity and effectiveness of these individuals. The benchmark will be tracked both at the individual level and in aggregate.

The state anticipates that Transition Coordinators will inform and disseminate transition packets to at least 85 percent of residents in the first year, climbing to 95 percent by year five, as shown in exhibit 6 below.

Exhibit 6 - Number of MFP-Eligible Residents Educated about the MFP Program

Calendar Year	Projected MFP-Eligible Residents	Number/Percent Educated about Program
CY 2011	100	85 (85 percent)
CY 2012	105	91 (87 percent)
CY 2013	110	98 (89 percent)
CY 2014	115	105 (91 percent)
CY 2015	120	112 (93 percent)
CY 2016	125	119 (95 percent)

Benchmark 5 – 80 percent of the initial MFP participants will remain in the community for at least 1 year after transition and the rate will increase by two percent in each subsequent year

To succeed, the MFP demonstration must not only transition participants out of the nursing facility but also provide the necessary supports to keep the majority of these individuals in the community for at least one year. The state has set a benchmark of 80 percent for the initial (year one) group of participants and will seek to increase the rate by two percentage points in each subsequent year. These targets are ambitious but the state believes its person centered care model is well suited to achieve this outcome. Exhibit 7 below presents for each calendar year the projected number of persons who will remain in the community one year after transitioning.

Exhibit 7 - Number of MFP Participants Who Remain in the Community after One Year

Calendar Year	Total Transitioning Residents	Number/Percent Remaining in Community after One Year
CY 2011	50	40 (80 percent)
CY 2012	55	45 (82 percent)
CY 2013	60	50 (84 percent)
CY 2014	65	56 (86 percent)
CY 2015	70	62 (88 percent)
CY 2016	75	68 (90 percent)

B. DEMONSTRATION POLICIES AND PROCEDURES

B.1 Participant Recruitment and Enrollment

Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, the Draft OP may include samples of a few recruitment and enrollment materials that will be disseminated to enrollees if developed. (please limit the pages of your application to those required) Your OP may include materials developed as appendices after the grant award is made and before the final approval of the OP

a. How will the service provider be selected and does the State intend to engage the State's Centers for Independent Living in some role in the transition process.

Participating service providers will consist of nursing facilities that have potential candidates for the MFP demonstration. There are approximately 2,000 Medicaid-eligible residents currently residing in Medicaid-participating nursing facilities across the state. Transition Coordinators will work with each of these nursing facilities to assess candidates for the MFP demonstration. Nursing facility staff will receive training about the MFP demonstration (refer to B.3.- Outreach/Marketing/Education for further information on training), including how to identify potential participants.

As previously discussed, the state will contract with organizations that do not act as direct service providers to serve as consultants to Transition Coordinators. The Vermont Center for Independent Living (VCIL) will be invited to serve as a contracted consultant. Vermont understands that Centers for Independent Living have performed similar tasks in other MFP demonstration states and fully expects the Vermont Center to participate as well.

The Vermont Center for Independent Living is a partner in Vermont's Aging and Disabilities Resource Connection project and already is playing an important role in supporting care transitions. Specifically, VCIL is serving as one of the Local Area Contacts for the MDS 3.0 Section Q discharge process for nursing homes. This expertise will be of great value to the state during the transition planning process for new MFP demonstration participants.

b. The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence. Please include a discussion of:

- *the information/data that will be utilized (i.e., use of MDS Section "Q" or other institutional data);*
- *how access to facilities and residents will be accomplished*
- *the information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information*

Criteria Used to Identify MFP Candidates

Eligible individuals will be those who meet all of the following conditions:

- Vermont resident
- Receiving nursing facility services
- Meets CMS requirements for consecutive days in facility
- Expresses a desire to return to a community setting

Processes to Identify Individuals for Transitioning

The information/data and processes that will be utilized to identify individuals meeting these criteria are outlined below.

1) DAIL-Initiated Identification

The MFP Data Analyst will generate a monthly report from paid claims data identifying residents who may have become eligible for MFP in the past 30 days based on length-of-stay. The report will be provided to the Transition Coordinators, who will make monthly visits to all nursing facilities in their regions. During the visits, the Transition Coordinators will follow-up on the information and consult with facility discharge planners. The visits will be mandatory and will occur as part of the state's utilization review process.

2) MDS 3.0 Section Q

DAIL has established a process similar to other states whereby nursing facility discharge planners and nursing staff review the MDS 3.0 Section Q information to determine whether a referral to a Local Contact Agency (LCA) can be made. If an individual wishes to speak with someone about returning to the community, the nursing facility will complete the MDS 3.0 Section Q Referral Form (Appendix B includes a copy of the Vermont Section Q protocol and a draft MDS 3.0 Section Q Referral Form). The completed referral form will be submitted to the LCA (the Vermont Aging and Disability Resource Connection partner agency serving the county in which the nursing facility is located). Referral forms will be submitted within ten business

days of completion to the LCAs and nursing facilities will attach a copy to the resident's medical record.

Once a referral is made, the LCA will screen the individual to determine whether he or she meets the MFP criteria. If the person does appear to meet the criteria, the LCA will contact an MFP Transition Coordinator to schedule a visit with the MFP candidate within five business days. The Transition Coordinator will discuss the MFP demonstration with the candidate and provide an MFP transition packet if he/she has a desire to return to the community and meets the MFP eligibility criteria. If the individual does not meet MFP or Choices for Care criteria, then the Transition Coordinator will refer the individual back to the LCA for further assistance with discharge planning.

3) Resident Self-Referrals

Upon determination of an expressed interest to return to the community by a resident or his/her legal guardian, an MFP Transition Coordinator will be contacted. This initial contact may come from the Long Term Care Ombudsman, Office of Public Guardian, a community agency, family members, guardians, facility residents, nursing facility patient liaisons, social workers, or others who may have met with the resident.

Prior to visiting the resident, the Transition Coordinator will notify a designated contact person at the respective nursing facility that the individual has expressed an interest in transition. This

notification is conducted as a professional courtesy to facilitate entry and access to facility residents by MFP Transition Coordinators and/or case managers.

Information Provided to MFP Candidates

The following information will be provided to individuals and the greater community to explain the MFP demonstration, the transition process and the options available:

- ***Transition packets*** - Transition Coordinators will meet with the potential transition participant, family member, guardian, and/or significant others to provide a comprehensive overview of the MFP demonstration program and Choices for Care. They will disseminate transition packets to eligible individuals at each of the nursing facilities that include: (1) cover letter; (2) MFP application (referral) form with information about who to call; (3) MFP Informed Consent form; (4) Brochure and Fact Sheet; (5) Eligibility Information; (6) Choices for Care Participant Handbook; and (7) Qualified Residence Form. The Transition Coordinator will answer questions, address concerns, and establish methods for on-going communication (phone, email, face-to-face, etc.). The transition packets are intended to assist the individuals in making an informed decision about transition to the community.
- ***Miscellaneous materials*** - The Vermont MFP demonstration identification process will rely on referrals and one-on-one outreach in the manner similar to the existing 1115 long-term waiver, Choices for Care. DAHL staff will mail MFP participant packets to interested individuals when they call for information. (Transition Coordinators will deliver packets in person to residents who request the information.) DAHL also will

create an MFP page on its website to provide programmatic information and offer materials in other languages as necessary.

c. The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting. If targeting certain facilities, the names of the identified facilities and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

The MFP demonstration will not be limited by geography or other criteria. It will be open to eligible residents of any Medicaid-participating nursing facility in the state.

d. The minimum residency period to conform to the changes made to Section 6071 by the ACA reducing the minimum number of consecutive days to 90 in an institutional setting with the statutory exception noted in the ACA; and who is responsible for assuring that the requirement has been met.

DAIL will target individuals who have been residing in Vermont nursing facilities for 90 or more consecutive days, not including the period of time the individual may have been admitted solely for purposes of receiving short-term rehabilitative services. The Transition Coordinator assigned to the respective nursing facility will be trained to review this information through medical record reviews and interviews of nursing facility staff to assure that this requirement has been met as well as the other MFP eligibility criteria noted above.

e. The process (who and when) for assuring that the MFP participant has been eligible for Medicaid at least one day prior to transition from the institution to the community.

Transition Coordinators will be responsible for determining whether the MFP participant has been eligible for and receiving Medicaid services at least one day prior to transition from the nursing facility to the community. The verification will be done through the use of the Medicaid

Eligibility System, whereby the Transition Coordinator accesses the information through the online portal and documents it in the participant's case record.

f. The process for determining that the provision of HCBS to a participant enables that participant to be transitioned from a qualified institution. Formal Level of Care determinations are not required prior to transitioning into the MFP demonstration for the 365 day period. States may elect to develop an assessment of eligibility that takes into consideration the readiness for an individual to transition into the community with identified transition services and appropriate long-term care services.

Transition Coordinators will perform a comprehensive transition assessment once it has been determined that a nursing facility resident meets MFP eligibility criteria and wishes to return to the community. The transition assessment is designed to evaluate the individual's readiness to transition into the community; assess the individual's level of risk; and identify his/her needs across several life domains including: safety, cognitive abilities, Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADL's), medical diagnoses, housing, financial, legal, community services, and informal and formal supports.

A determination will be made about the candidate's readiness to transition based on the transition assessment and risk assessment results. If the candidate meets transition criteria, the results of the transition assessment will be used to develop an individualized care plan and to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The Transition Coordinator, an assigned case manager and the MFP participant will work as a team to develop the care plan.

The care planning process also will include development of a contingency or “backup” plan for each service. The back-up plan will become part of the individual’s larger care plan.

g. The State’s policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.

Individuals readmitted to an institution, including a hospital, after completing 12 months of demonstration services, will remain candidates for another 12 months of demonstration services during the grant period. The same eligibility criteria will apply to the second transition. A thorough review of the original transition including the transition assessment and care plan will be conducted to mitigate any obstacles for a second transition.

To prevent readmission to an institution, case managers will perform a re-assessment of the MFP participant annually and any time there is a significant change in status. A review and update to the care plan may be necessary at any time but will be required on an annual basis.

If the MFP participant must be institutionalized, the individual, upon condition stabilization and a desire to return to the community, will be reassessed for transition back to the community by a Transition Coordinator, and a new care plan will be developed. The individual’s re-institutionalization will be taken into consideration during the reassessment to enable the assigned case manager to address the conditions that resulted in the original deterioration.

Ultimately, the decision to return to the community remains with the individual and/or his/her representative. Individuals who want to relocate and who meet the eligibility criteria will be encouraged to return to the community.

h. The State's procedures and processes to ensure those participants, and their families will have the requisite information to make informed choices about supports and services. The description shall address:

i. How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.

ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished

The MFP Project Director will be responsible for training DAIL staff, in conjunction with the Community Development Specialists. Training will occur over a period of four to six weeks. MFP staff will then perform the necessary training and community outreach to MFP participants and the general population.

During the transition planning sessions, the Transition Coordinator will provide each participant with a Choices for Care Participant Handbook describing their rights and responsibilities, as well as the state's protections from abuse, neglect, and exploitation. The handbook will also be updated to include information on how participants and/or their representative can notify the appropriate authorities or entities when the participant may have experienced abuse, neglect, or exploitation. (Appendix C contains a copy of the current Handbook.)

Transition Coordinators will train participants on how complaints of abuse, neglect and exploitation are investigated by DAIL and then referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Program Integrity Unit. Information pertaining to abuse and neglect will also be disseminated by the participant's assigned case manager once they are living in the community setting. The case manager will review the information provided in the Choices for Care Participant Handbook as well as reinforce the general MFP training that was performed initially by the Transition Coordinator before the individual transitioned.

The Transition Coordinator will monitor the participant in the community weekly during the first six months (with at least one face-to-face visit per month) and collaborate with the assigned case manager. During this "on-boarding" period, training and education about MFP will be reinforced and individual questions answered. After the first six months, the assigned case manager will have monthly contact with the participant during which time training and information will be reviewed and reinforced.

B.2 Informed Consent and Guardianship

a. Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

All participants (or as appropriate, family members or guardians) will be required to sign a consent form to enroll in Vermont's MFP demonstration. By signing the consent form, participants acknowledge that they have freely chosen to participate, are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and thereafter, are aware of the waiver requirements and are informed of their rights and responsibilities as a participant in the demonstration.

Procedures to Obtain Consent

DAIL will provide interested parties with an "MFP Transition Packet," which includes a (1) cover letter; (2) MFP application (referral) form with information about who to call; (3) Informed Consent form; (4) Brochure and Fact Sheet; (5) Eligibility Information; (6) Choices For Care Participant Handbook; and (7) Qualified Residence Form. Transition Coordinators will provide the packets in person whenever possible. If the applicant requests that the packet be mailed, the Transition Coordinator will make a follow-up contact after informational materials are sent by DAIL to schedule a transition planning meeting.

A Transition Coordinator will thoroughly review the contents of the packet during the onsite transition meeting he/she has with a potential applicant and/or guardian and prior to asking applicants or guardians to sign the consent form. The meeting with the Transition Coordinator will provide an opportunity for specific dialogue focused on all aspects of the MFP process, including pre- and post-transition activities. The participant and/or guardian will also receive a clear explanation about their rights and responsibilities as well as procedures for incident reporting and complaints. The Transition Coordinator will address any questions or concerns about the project during this time.

Nursing facility residents who are interested in moving to the community and who do not require a guardian or representative will then sign the MFP Consent Form and participate in the MFP intake process. A draft of the MFP Consent Form is located in Appendix D.

In the event the participant requires a representative to provide informed consent for the MFP demonstration, the consent for participation may be provided by the participant's family member, caregiver, a health care agent named in a health care power of attorney, an attorney-in-fact named in a durable power of attorney, or the legal representative or surrogate decision-maker who has responsibility for the individual's living arrangement. In situations where there is a legal representative or surrogate decision maker, the Transition Coordinator will review legal documentation to ensure the individual possesses the authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

b. Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.

Private Guardianship

In Vermont, a court may enter a judgment pursuant to subsection 3068(f) of Title 14, Chapter 11 of the Vermont Statutes and appoint a guardian if it determines that the respondent is unable to manage, without the supervision of a guardian, any or all aspects of his or her personal care and financial affairs. The court must grant powers to the guardian in the least restrictive manner appropriate to the circumstances of the respondent and consistent with any advance directive. Guardianship powers may be ordered only to the extent required by the respondent's actual mental and adaptive limitations. The court must specify the powers the guardian shall have and may further restrict each power so as to preserve the respondent's authority to make decisions commensurate with respondent's ability to do so.

The guardian must maintain close contact with the person under guardianship and encourage maximum self-reliance on the part of the person under guardianship. The guardian must always serve the interests of the person under guardianship and must bring any potential conflicts of interest to the attention of the court.

In addition to the powers vested in the guardian by the court pursuant to section 3069 of Title 14, the court may order the guardian to assure that the person under guardianship receives those benefits and services to which he or she is lawfully entitled and needs to maximize his or her opportunity for social and financial independence. Those benefits and services include, but are not limited to:

- Residential services for a person under guardianship who lacks adequate housing;
- Nutrition services;
- Medical and dental services, including home health care; and
- Therapeutic and Habilitative services, adult education, vocational rehabilitation or other appropriate services.

Competent individuals of at least 18 years of age may serve as guardians. In appointing an individual to serve as guardian, the court shall take into consideration:

- The nomination of a guardian in an advance directive or in a will;
- Any current or past expressed preferences of the respondent;
- The geographic location of the proposed guardian;
- The relationship of the proposed guardian and the respondent;
- The ability of the proposed guardian to carry out the powers and duties of the guardianship;
- The willingness and ability of the proposed guardian to communicate with the respondent and to respect the respondent's choices and preferences;

- Potential financial conflicts of interest between the respondent and the proposed guardian, and any conflicts that may arise if the proposed guardian is an employee of a boarding home, residential care home, assisted living residence, nursing home, group home, developmental home, correctional facility, psychiatric unit at a designated hospital, or other similar facility in which the respondent resides or is receiving care; and
- Results of any background checks.

Public Guardianship

An Office of Public Guardian is established within DAIL for the purpose of making guardianship services available to mentally disabled persons 60 years of age or older for whom the probate court is unable to appoint a guardian from the private sector. In addition to the powers and duties of guardians set forth in the statute, the Office of Public Guardian through its designees must:

- Be considered a person interested in the welfare of the ward for purposes of filing a motion for termination or modification of guardianship.
- Visit the facility in which the ward is to be placed if it is proposed that the ward be placed outside his or her home.
- Monitor the ward and the ward's care and progress on a continuing basis. Monitoring must, at a minimum, consist of quarterly personal contact with the ward. The Office of Public Guardian must maintain a written record of each visit with a ward. A copy of this record must be filed with the probate division of the superior court as part of the required annual report. The office, through its designees, must maintain periodic

contact with all individuals and agencies, public or private, providing care or related services to the ward.

When an MFP participant has a guardian, the Transition Coordinator will verify the guardian's appointment by either viewing the guardianship papers or by contacting the probate court directly. As is the case today for Choices for Care, the Transition Coordinator will require a guardian's signature on the all forms and documents pertaining to the program.

Guardians will be invited to all transition meetings and other relevant encounters with the participant. Their maximum participation will be encouraged throughout the process.

It will be the Transition Coordinator's responsibility to educate the guardian about Vermont's MFP demonstration and the transition and post transition processes. The guardian must report recent visits or interactions to the Transition Coordinator at the time the consent is signed and on a quarterly basis. To the extent documentation of such contacts are available through the Area Agencies on Aging or other public surrogate organizations, the Transition Coordinator will request information on recent visits and file this in the participant's case record.

Private guardians will be encouraged to visit individuals for whom they have been awarded guardianship and to provide information on the frequency of their visits to the Transition Coordinator. A minimum of one visit between the guardian and the participant must be

documented within the six-month period prior to transition and then every six months thereafter.

The Transition Coordinator will review and document as to whether or not guardians have recent knowledge of a participant's welfare if they are making decisions on behalf of the participant. Such documentation will be in the form of case notes, care planning meetings, social services notes, and telephone records reflecting active participation in decision making. If the Transition Coordinator has reason to believe that a private guardian is not acting in the best interests of the participant, he/she will report such information to Adult Protective Services within DAIL's Division of Licensing and Protection.

B.3 Outreach/Marketing/Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: The OP Draft required in this application does not require a State to submit marketing materials at this time. All marketing materials will be submitted during the final approval process for the Operational Protocol.

Please provide:

a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);

Vermont's Choices for Care program provides Long-Term Care Services for frail elders and adult Vermonters with physical disabilities. Created in 2005 as an 1115 waiver, the program is already well established and offers long-term services and support systems throughout the state. Because of the success and awareness of this program, participation in the MFP demonstration for enrollees, nursing facilities, state staff and other key stakeholders is expected to be high.

To assure the successful implementation of Vermont's MFP demonstration, generic outreach and marketing materials will be developed and used across a wide range of audiences and locations throughout the state. The materials will be modified to meet the needs of the different audiences, such as nursing facilities, enrollees, family members, and advocacy organizations, while at the same time also contain some general facts and information. The primary goal for Vermont's marketing and outreach campaign will be to ensure the MFP demonstration is easily recognized, understood and accessible to its target audiences.

Enrollees

Participants in Vermont's MFP demonstration will be those who have expressed an interest in transitioning and who wish to live and receive supports and services in the community of their choosing. Additionally, there will be family members, caregivers, guardians, and advocates of people who reside in nursing homes who will need to be educated about the program. To that end, the following is a preliminary list of the information that will be communicated:

- The existence of Vermont's MFP demonstration and its objectives;
- The program opportunities afforded through MFP, such as to move into a community setting, to become more independent and to access an array of community-based services;
- Eligibility requirements;
- Benefits and services (including self-direction);
- How to participate;
- The transition process (pre and post-transition);
- Your rights and responsibilities; and
- Who to contact to learn more about how to get started

Participating Providers

Providers in Vermont's MFP demonstration include medical directors, administrators, discharge planners and social workers employed in nursing facilities as well as well as the array of home and community-based service providers. In addition to what is communicated to enrollees, the state will furnish the following information to providers:

- How people can participate in Vermont’s MFP demonstration;
- Identification of potential participants;
- How to enroll in the program;
- When and how to receive training about the program;
- Their role in helping people participate in the program; and
- Program implementation and next steps

State Outreach/Education/Intake Staff

“State staff” refers to DAIL employees and their contractors who will be involved in the MFP demonstration, as well as staff at other Vermont state and county-level agencies interacting with demonstration participants or otherwise supporting the program. The following topics, in addition to the above information for enrollees and providers, will be covered for this audience:

- Upcoming training opportunities;
- Overview of the initiative and their roles;
- How they can make the program a success;
- Disparities in the community to be addressed (i.e. housing, supports);
- Program sustainability;
- Program statistics and data collection;
- Program resources;
- Vermont’s community service capacity; and
- Who to contact for programmatic and other questions

b. Types of media to be used;

In order to raise awareness about the MFP demonstration, Vermont will use multiple media and communication tools to reach the many stakeholders involved, including at least the methods described below.

Enrollees/Families/Caregivers/Guardians/Advocates/General Community

These individuals will receive information on Vermont's MFP demonstration via a brochure and factsheet that features a description of the initiative, eligibility requirements, benefits and services, how to participate and how to obtain additional information. DAIL will include a senior helpline phone number to call for more information. The phone number will immediately direct callers to their local Area Agency on Aging based on the caller's location. Callers also will be able to inquire about the program by calling Vermont's 211 line and any of the ADRC partner agencies, which includes the Area Agencies on Aging, VCIL and the Brain Injury Association of Vermont.

DAIL also will use mass media, including advertisements and press releases in local newspapers, relevant newsletters and publications throughout the state. The department also will broadcast messages on television and radio to announce the roll-out of the demonstration as well as highlight how individuals who are aged or have disabilities have transitioned from a nursing facility and live successfully in their communities.

DAIL staff (or the Area Agency on Aging) will mail an MFP participant packet to interested individuals when they call for more information. The packet will include a (1) cover letter; (2) MFP application (referral) form with information about who to call; (3) MFP Informed Consent form; (4) Brochure and Fact Sheet; (5) Eligibility Information; (6) Choices For Care Participant Handbook; and (7) Qualified Residence Form. Transition Coordinators will also perform in-person visits to nursing facilities to discuss the program with residents or potential candidates as well as provide some of the written materials previously mentioned.

DAIL will have a dedicated page within the Choices for Care website designed to offer a information about the MFP demonstration to an array of audiences, including potential participants and their families, providers and other program stakeholders. Information will be made available in alternative formats, such as CDs, tapes, video upon request.

Participating Providers

DAIL will use many of the outreach tools detailed above for participating providers.

Additionally, letters will be provided to administrators of nursing facilities across the state for which individuals will be transitioning. Letters will explain the project as well as what to expect for the period of the demonstration. Another series of letters will be disseminated to home- and community-based service providers to inform them about the program and to provide information about upcoming community forums and training sessions. DAIL will also host community forums to explain the programs to providers as well as perform a number of onsite

visits to nursing facilities and community-based providers. Choices for Care Waiver Teams will be an additional forum to advance this project to the local providers and case managers.

State Outreach/Education/Intake Staff

State staff and advocacy groups will receive information via DAIL's website, fact sheets, brochures and training sessions. Similar to the provider outreach initiatives, DAIL will host community forums to explain the program and how to participate.

c. Specific geographical areas to be targeted;

Since the MFP demonstration is being implemented statewide, the area to be targeted will be the entire state of Vermont.

d. Locations where such information will be disseminated;

Information about the program will be disseminated to multiple audiences across the state in numerous locations, including but not limited to: nursing facilities; provider offices; community-based providers; county departments; local advocacy organizations, including the Center for Independent Living; professional associations; state agencies; non-profit organizations; Area Agencies on Aging/ADRCs; local libraries; and other community locations places (e.g., stores and recreation centers).

e. Staff training plans, plans for State forums or seminars to educate the public;

Training sessions relevant to MFP will be offered to health care providers and professionals working with this population. The groups to be trained by the MFP Project Director and Community Development Specialists are discussed below.

Nursing Facilities

DAIL will direct training efforts to nursing facility social workers and discharge planners, covering MFP eligibility requirements and the program referral process. Onsite training sessions will take place at designated nursing facilities across the state.

Transition Coordinators, Case Managers and other MFP Staff

Transition Coordinators, case managers and all other MFP staff will receive specific training targeted to their role so they can in turn train demonstration participants. The training will include:

- Overview of the MFP demonstration;
- Eligibility requirements;
- Benefits and services;
- Vermont MFP Operating Protocol;
- Self-direction;
- Quality Management;
- MFP Referral and Intake Process;
- MFP Assessment, Care Planning and Case Management;

- MFP Transition Process;
- MFP providers and resources;
- MFP Policies and procedures, including informed consent and back-up planning;
- Participant rights and responsibilities;
- Documentation and its importance;
- Agency coordination;
- Safety in the Home; and
- Special Conditions, including behavioral health and dementia

Training will occur over a four to six week period and include both classroom and field-based activities. The MFP Project Director or designee will provide follow-up training as necessary, which, in the case of Transition Coordinators, could include shadowing the individual for a period of time until satisfied they can work independently.

Providers of MFP Services

Vermont has numerous home and community-based service providers and advocacy groups, including home health agencies. Those participating in MFP will be required to attend training on a semi-annual basis. The content of the training will be similar to the training for Transition Coordinators. Training sessions will be offered onsite at locations throughout the state.

State Forums to Educate the Public

State forums will be offered annually beginning in the spring of 2011 and will focus on educating participants, advocates, state, county and local agencies and the general public about Vermont's MFP demonstration. Specific topical training will be offered to meet the needs of particular groups and will be held at times and locations where the demand exists. DAIL also will assemble ad-hoc workgroups/taskforces as the need arises to address project challenges and to address solutions. (See section 4.B for additional information on the demonstration's ad hoc stakeholder work group.)

f. The availability of bilingual materials/interpretation services and services for individuals with special needs;

Vermont accommodates individuals with special needs and those with Limited English Proficiency (LEP) under the existing waiver program and will make such services available at no cost to MFP demonstration participants. In-person interpreter services for all needed languages are provided through the Association of Africans Living in Vermont. DAIL also will provide TDD services for hearing impaired individuals. Outreach and educational materials will be made available, upon request, in alternative formats, such as Braille, large font letters, audiotape, and non-English languages.

g. A description of how eligible individuals will be informed of cost sharing responsibilities.

Vermont's MFP participants will not be required to pay a cost-share deductible for the program aside from the standard share of cost they are paying today.

B.4 Stakeholder Involvement

Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant. Please include:

a. A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.

Vermont has a longstanding commitment to the inclusion of private and public stakeholders in the design, development and evaluation of new initiatives for its Global Commitment to Health and Choices for Care waiver programs. Prior to making the decision to submit an application under the Money Follows the Person demonstration, the state consulted with a broad range of stakeholders through a series of formal public meetings and in-depth interviews.

Exhibit 8 below identifies the private and public stakeholder groups consulted during the development of the application. These same groups will continue to assist in the implementation of the demonstration, if a grant is awarded, through the mechanisms described further below.

Exhibit 8 - Public and Private Stakeholders

Private Stakeholders	Public Stakeholders
<ul style="list-style-type: none"> ▪ Consumers (multiple) ▪ Community of Vermont Elders ▪ Vermont Center for Independent Living ▪ HomeShare Vermont ▪ Vermont Association of Area Agencies on Aging ▪ Visiting Nurse Association of Chittenden/Grand Isle Counties ▪ Vermont Assembly of Home Health & Hospice Agencies ▪ Individual HCBS providers (multiple) ▪ Vermont Health Care Association ▪ Vermont nursing facilities (multiple) ▪ Vermont Designated Agencies (community mental health centers) 	<ul style="list-style-type: none"> ▪ Office of Public Guardian ▪ Department of Vermont Health Access ▪ Department of Health ▪ Department of Mental Health ▪ Department of Disabilities, Aging and Independent Living <ul style="list-style-type: none"> – Division of Disability and Aging Services (DDAS) – Division of Licensing & Protection – DDAS Long Term Care Clinical Coordinators (multiple)

The meetings and interviews explored the following topics:

- What types of nursing facility residents would benefit from participation in the demonstration?
- How should stakeholders assist in conducting outreach and identifying eligible residents for the demonstration if a grant is awarded?
- What barriers to transition should the demonstration seek to address, in terms of transition coordination activities, housing alternatives and ongoing home- and community-based services?

- How adequate is HCBS capacity and what gaps must be addressed to facilitate transition of eligible nursing facility residents?
- How should the demonstration be integrated into the broader Choices for Care waiver program?
- What would be the potential impact on the broader Choices for Care system, in terms of expanding options for all long-term care beneficiaries, including new entrants into the program still residing in the community?
- Should the state proceed with submitting an application?

Stakeholder recommendations have had a significant impact on the design of the proposed demonstration, including with respect to defining target populations and the support services and housing alternatives necessary to overcome barriers to transition. The inclusiveness of the process has resulted in broad support for the application, as reflected in the letters of endorsement received from consumer, provider and public stakeholder representatives. The letters are included in Appendix E of the application.

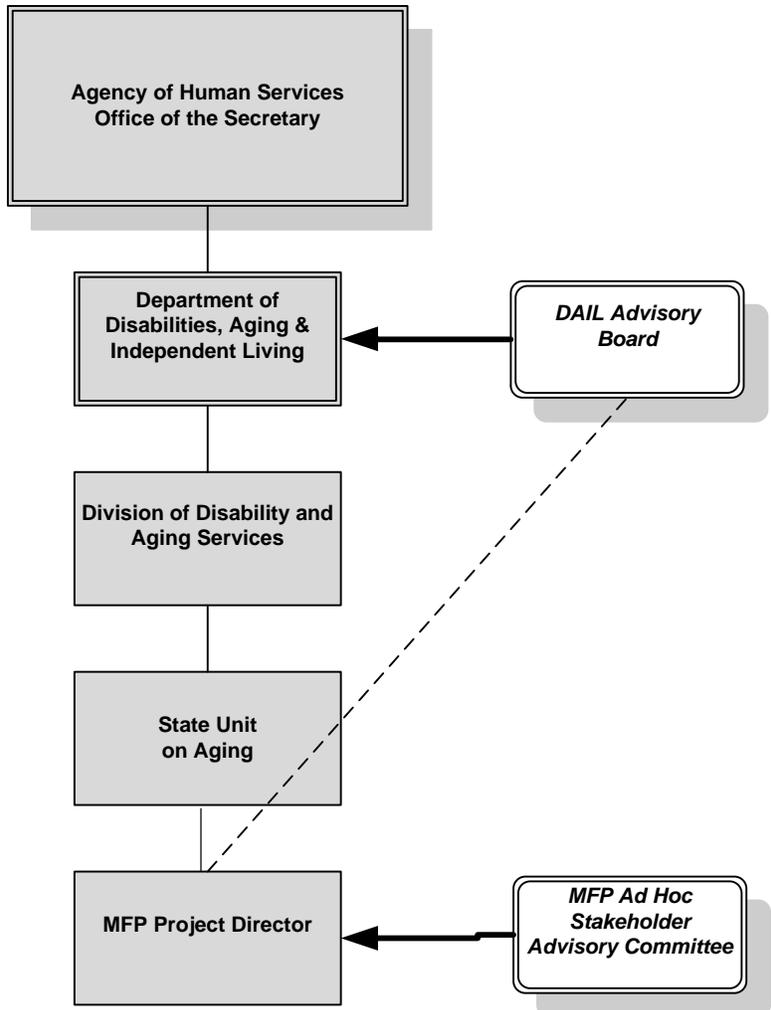
The state will collaborate with stakeholders on the development, implementation and operation of the demonstration through a formal structure created for such consultation: the Department of Disabilities, Aging and Independent Living Advisory Board. As required by statute, a majority of the Board members are older persons and persons with disabilities, selected for their familiarity with and interest in programs and issues affecting the interests of older persons or persons with disabilities.

The DAIL Advisory Board meets monthly and serves as an active forum for discussion of new state initiatives and existing programs. The MFP Project Director will provide regular updates to the Board during implementation of the demonstration and consult on strategies for addressing and resolving challenges that arise.

In addition to the DAIL Advisory Board, the MFP Project Director also will collaborate with an ad hoc committee of consumer, provider and public stakeholders originally convened to explore options for expanding placement alternatives under Choices for Care. The committee, which has been actively engaged in designing an Adult Family Care benefit, was consulted on the design of the demonstration from its earliest stages through submission of the application. Committee members will continue to advise the MFP Project Director and other DAIL staff on the implementation of the demonstration, if a grant is awarded.

Exhibit 9 below illustrates the two formal channels through which stakeholder views will be heard and their relationship to the organizational structure of the grant.

Exhibit 9 - Formal Stakeholder Structure



b. A brief description of how consumers' will be involved in the demonstration.

As discussed above, Choices for Care consumers participated in designing the demonstration model through their involvement in both the DAIL Advisory Board and Ad Hoc Stakeholder Advisory Committee. Consumer representatives were forceful advocates for creation of the new housing alternative (Adult Family Care) and one-time transition payment proposed for the demonstration population. They also offered important insights into the other support services that will be necessary to facilitate the successful transition of long time nursing facility residents back into the community.

Although not consumers themselves, representatives from the Vermont Office of Public Guardian (OPG) played, and will continue to play a vital role in the demonstration. During the design phase, OPG representatives assisted in researching the number of potential eligible nursing facility residents and consulted on the barriers to transition confronting aged and disabled persons under their guardianship. OPG representatives will continue to be actively engaged during the life of the demonstration in identifying, and facilitating the transition of, residents under public guardianship.

Other consumer representatives will continue to be involved in the demonstration through their participation on the two committees, and through less formal methods. As residents of a small state, Vermont citizens also regularly have the opportunity to meet and correspond informally with public officials. Their opinions are valued and treated with respect, regardless of the venue in which they are provided.

c. A brief description of community and institutional providers' involvement in the demonstration.

The Vermont Health Care Association and its member nursing facilities have a collaborative relationship with the state and are active partners in the existing Choices for Care waiver. The industry worked closely with the state in the summer and fall of 2010 to conduct an initial feasibility analysis for the demonstration. The analysis included onsite visits to eleven facilities selected to be representative of the 44 Medicaid-participating facilities across the state.

Clinicians working on behalf of DAIL met with administrators and social service/discharge planning directors at the eleven facilities to review their current resident population and determine the number who would qualify under the demonstration. Findings were used, in combination with data from other stakeholders (e.g., Office of Public Guardian) to estimate the total number of demonstration-eligible residents in the state.

The nursing home representatives also conferred with DAIL on the barriers to transition facing demonstration-eligible residents in their facilities. These included the need for one-time transition funding, new housing options and accessible community mental health services. The demonstration design ultimately addressed all of these barriers through a combination of new benefits, proposed placement options and strategies for ensuring access to behavioral health services through the state's Designated Agency (CMHC) system.

Vermont's community providers also participated in the demonstration design through their involvement in the two committees and through regular consultation with DAIL staff. They have been particularly active in assisting with creation of the proposed Adult Family Care housing option, including with respect to provider training, and safety and licensing.

Choices for Care case managers and community providers will continue to play an integral role under the demonstration, as the front line organizations and individuals responsible for ensuring the safety and quality-of-life of demonstration participants. This will include management of transition payments, provision of intensive case management following discharge and delivery of home- and community-based services in strict accordance with member care plans.

d. A description of the consumers' and community and institutional providers' roles and responsibilities throughout the demonstration.

As discussed above, consumers, consumer representatives and institutional providers will participate in oversight of the MFP demonstration through their participation in the Advisory Board and ad hoc committee.

e. The operational activities in which the consumers and community and institutional providers are involved.

Consumers will make the fundamental decision as to where they will reside and those who elect to self-direct their care will become employers within the demonstration.

Nursing Facilities will be responsible for identifying eligible residents through responses to Section Q of the MDS 3.0 and notifying MFP Transition Coordinators to begin the discharge planning process. They will be part of the transition team with shared responsibility for ensuring residents return to the community in a safe fashion.

Community providers will serve as the core network for provision of services under the demonstration and will be active participants in the stakeholder process through their involvement in the ad hoc committee.

B.5 Benefits and Services

a. Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (1915 a, b, c or combination waiver, 1115 demonstration, Medicaid State Plan, 1915i and 1915j, etc.). For all HCBS demonstration services and supplemental demonstration services State must detail the plan for providers or the network used to deliver these services. Some demonstration services may be added to existing 1915 waivers during the MFP demonstration period, but the services that are not added and the supplemental services not paid for through Medicaid will end at the 365th day for each individual participant.

Service Delivery and Financing Model

Vermont MFP demonstration participants will be enrolled in the state's Section 1115 Choices for Care waiver. A separate demonstration waiver will not be created for the ongoing services provided through the MFP project. Choices for Care is a managed care waiver, although Vermont does not utilize managed care organizations (MCOs) to administer the waiver services. Instead, payment is made using a fee-for-service model that will continue to be used for the MFP demonstration.

At the termination of the demonstration period, individuals will continue to receive Qualified HCBS through Choices for Care as long as they meet the eligibility requirements of the program. Pursuant to terms and conditions of the grant, MFP demonstration services will not be available after the 365-day demonstration period. Vermont is not proposing to offer any supplemental services as part of the MFP demonstration.

Providers or Network to Deliver Demonstration Services

Vermont will rely on its current network of Choices for Care providers to deliver services for the MFP demonstration. In Vermont, many of these services are provided by home health agencies. Vermont currently has eleven regional not-for-profit home health agencies and one statewide for-profit provider. Each of the not-for-profit agencies serves a defined geographic region on a non-competitive basis. This model has been in place in Vermont for many years, and has been shown to work best in an environment that is largely rural, and not conducive to competitively driven profit centers. Other services will be provided by community-based entities, such as small residential care homes and assisted living residences, Area Agencies on Aging, Durable Medical Equipment vendors, home adaptation contractors, adult day centers, and individual attendants hired and supervised by Demonstration enrollees.

Vermont will offer a one-time transition payment to participants in the amount of \$2,500. These transition payments will be controlled and monitored by the Transition Coordinator assigned to the participant. Since this will be a benefit in the form of a payment and not an actual service, DAIL will not require a network of providers for this demonstration service option.

*b. List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). **Do not include acute care service or institutional services that will be paid for through the regular Medicaid program.** In a chart, divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed*

account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

Service Package for MFP Participants

Qualified HCBS

Under Choices for Care, fee-for-service providers and individuals acting under the consumer/surrogate directed options provide the home- and community-based services authorized under the enrollee's comprehensive care plan. The same system will be in effect for the MFP demonstration program. Claims from agency providers will be submitted and reimbursed by the state's Fiscal Intermediary (currently Hewlett Packard) in accordance with requirements and fee schedules in effect for the program. Claims generated by services provided for consumer or surrogate directed care will be processed by the state's Fiscal/Employer Agent who will, in turn submit these claims to the Medicaid Fiscal Intermediary. Individual providers or groups of providers will not be capitated or at-risk financially for the cost of care for any individual enrollee or group of enrollees.

Vermont will add one additional Qualified HCB service as part of the MFP demonstration: Adult Family Care. An Adult Family Care home is a private, single-family residence in which the provider cannot be related to the resident. Adult Family Care homes can provide in-home services to waiver participants, including personal care, companion care, medication oversight, and transportation. The services are provided in a home-like environment that includes a private bedroom, a private or semi-private bathroom, home-cooked meals, a common living

area, and assistance with activities of daily living. Residential Care Homes that house three or four residents are subject to licensure by DAIL as a residential care facility. Adult Family Care Homes, which will house one or two residents, will be subject to safety inspection and continuing oversight by DAIL staff or case management staff from one of the Choices for Care case management agencies.

Demonstration Services

Vermont will introduce a one-time transition payment for individuals who are moving from a nursing facility to a community setting or another living arrangement where the person is directly responsible for his/her own living expenses. The one-time transition payment is furnished only to the extent that the person is unable to meet such expenses, or when the support cannot be obtained from other sources. Transition services do not include any services not associated with household start-up. The Transition Coordinator assigned to the participant will monitor the use of the funds so that the funds are used as intended and only in the amount needed.

The monetary limit for transition services is \$2,500. Transition services are only available once in the lifetime of waiver enrollment, and must be accessed within 90 days of the first day of transition from the nursing facility. Sound judgment will be used when approving services to ensure purchases are modest and reasonable. Funds cannot be used to pay existing bills or past due balances.

HCBS Supplemental Services

Vermont does not intend to offer supplemental services.

Exhibit 10 below summarizes the MFP benefit package by service type.

Exhibit 10 – Vermont MFP Benefits

Service Options	Qualified HCBS	HCBS Demonstration	Supplemental Demonstration
Personal Care Services	X		
Respite Care	X		
Companion Services	X		
Adult Day Services	X		
Personal Emergency Response Systems	X		
Assistive Devices	X		
Home Modifications	X		
Enhanced Residential Care Home/Assisted Living Residences	X		
Case Management Services	X		
Homemaker Services	X		
Other living arrangements*	X		
One-time transition payment		X	
Case Management**	X		
Adult Family Care	X (new)		

* *Optional Services – Availability dependent on funding, subject to overall budget neutrality limitations.*

** *Vermont has a review process under Choices for Care whereby individuals who need more intensive case management (i.e., more case management contact time) can be authorized to receive additional minutes. MFP participants will be eligible to receive additional case management time through this process.*

B.6 Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

a. A description of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;

MFP demonstration participants will be utilizing Vermont's existing waiver program, Choices for Care, for the delivery of home and community-based services and supports. The current systems for consumer supports that are approved and in place for Choices for Care will be used by MFP demonstration participants as well, both during the MFP demonstration and thereafter. Vermont has begun and will continue to develop the necessary back-up systems and supports as part of this demonstration program to ensure the necessary infrastructure is in place.

As part of this endeavor, and as discussed in B3. Outreach/Marketing/Education, DAIL will develop a transition packet for distribution to all potential participants. The packet will contain an array of educational materials outlining the services and supports provided through the MFP demonstration. The materials will include information on procedures for accessing needed assistance and supports, including 24-hour backup systems. Potential participants also will be provided with a "Just in Case" booklet to be used for personal emergency preparedness planning.

Each demonstration participant will be provided with a transition packet and training as well as transition planning services by a Transition Coordinator prior to moving from a nursing facility

into the community. The materials and services will ensure that participants have access to the assistance and support that will be available to them as part of the MFP demonstration.

An individualized care plan will be developed in collaboration with each MFP participant, the Transition Coordinator and the assigned case manager prior to transition into the community. The care plan will address the individual's needs as they relate to supports, services and emergency backup plans.

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

A copy of the care plan, backup plan and emergency contact list will be placed in a conspicuous location in the participant's home. The case manager will also maintain copies of these materials in their files. For additional information on risk assessment/mitigation, critical incident reporting systems, and 24-hour backup, please refer to the Quality section, B.8.

b. A description of any 24 hour backup systems accessible by demonstration participants including critical services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website). Include information for back-up systems including but not limited to:

i. Transportation

ii. Direct service workers;

iii. Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are made); and

iv. Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.

24 hour Backup Systems

For MFP participants, the first level of backup will be identified as part of their care plan (the backup plan) and include at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. The plan also will include a list of emergency contacts.

The second level of back-up will be the assigned case manager/case management agency. If the back-up provider on the care plan is not able to resolve the issues for the participant, the case manager or their agency will be contacted for assistance.

Case management agencies are required to offer 24-hour telephone access through an answering service or other means. However, as a further safety measure, DAIL plans to contract with Vermont 211 to provide 24 hour backup services for MFP participants.

Vermont 211 is a toll-free information and referral telephone service where trained call specialists provide information, problem solve and refer callers to government programs,

community-based organizations, support groups, and other local resources across the state.

Vermont 211 is available 24 hours a day, 7 days a week and offers live translation services for 170 languages. MFP participants can be transferred to 911, crisis services, Adult Protective Services and other agencies that can assist them. Call specialists are trained to assist callers with an array of services including, but not limited to, the following:

- Clothing and Thrift Shops
- Consumer Services
- Crisis Services
- Discrimination Assistance
- Domestic and Sexual Violence Services
- Education—GED Instruction, Computer Classes
- Employment Services
- Food Shelves and Nutrition Programs
- Health Care Services
- Alcohol and Drug Programs
- Housing—Homeless Prevention, Shelter, Tenants’ Rights
- Independent Living Services
- Legal Assistance
- Mental Health Care and Counseling
- Mentoring
- Senior Information & Assistance
- Stop Smoking Programs

- Support Groups
- Transportation
- Utility Assistance

DAIL will train VT-211 on all aspects of MFP as well as provide phone numbers to which callers can be referred or transferred. VT-211 will be required to document and track the receipt of calls and requests.

Call metrics will be tracked to monitor responsiveness and timeliness with respect to consumer calls as well as the number and type of participant requests for critical backup. All reports will be submitted to an MFP QM specialist at a pre-determined frequency. The QM Specialist will analyze and track and trend this information in order to identify any improvements or modifications that need to be made for the program. For each MFP participant who requires emergency backup services, follow-up contact will be made to ensure the services are being provided.

Transportation

Due to Vermont's rural nature, there is not one universal back-up system for transportation available to Choices for Care waiver participants. One of the first duties of the Community Development Specialist will be to develop a comprehensive list of transportation options available to MFP participants. The list will identify all transportation options by local area and

include contact phone numbers, the process for scheduling transportation and procedures for filing complaints.

This list will be made available to MFP participants, Transition Coordinators and case managers. The assigned case manager will provide all MFP participants with telephone numbers and contact names for transportation in their community or will place the call for the participant as necessary to arrange for transportation services.

Direct Service Workers

All HCBS providers under contract with the state are required to have protocols for replacing workers in the event that scheduled staff become unavailable. The 24 hour backup system will not supplant these contractual relationships already in place. However, the 24 hour backup system attendants will document reliability of the contracted provider and will assist with calls to the provider when necessary. Documentation will be reviewed by the QM Specialists.

The case manager will provide all MFP participants with his/her agency's telephone number as well as contact names and phone numbers for all of the service providers listed on in the care plan, in the event the participant experiences an interruption in services.

As is the case with Choices for Care today, all MFP participants will be required to have an emergency backup plan developed as part of their care plan. This includes participants who use traditional HCBS services as well as those who choose the self-direction option. An alternative

provider(s) will be identified as an emergency backup at the time that the initial plans are written with the case manager. For individuals who choose self- or surrogate-directed care, Vermont's Direct Care Worker Registry offers workers the option to state whether they are interested in doing on-call work. Consumers could use this option to develop a cadre of workers who are willing to cover their care on an as-needed basis.

Repair and Replacement of Durable Medical and other Equipment

During the development of the care plan, individuals in need of durable medical equipment (DME) and/or other equipment will be provided with contact information for contracted vendors in their area. Once a vendor(s) is selected, the case manager will provide MFP participants with the telephone numbers and contact names of who they should call when they experience a problem with durable medical equipment or other equipment. The MFP participant or the participant's case manager will communicate any equipment issues to contracted DME vendors so the necessary intervention can take place, such as the provision of loan equipment when repairs are made. DME providers are expected to maintain adequate and continuing service-support for Medicaid beneficiaries.

Access to Medical Care

The participant's case manager will assist with arranging services and ensuring that services are being delivered in accordance with the care plan frequency. The participant will be trained on how to schedule appointments and the assigned case manager will assist as necessary with

making initial appointment with HCBS and other service providers, such as the participant primary care physician for preventive and/or follow-up care.

The case manager will also assist the participant in dealing with problems or issues with appointments and how to get care issues resolved. The case manager will document phone calls with the participant and his/her providers in the member's case record and provide the necessary follow-up as part of the ongoing case management process.

In the event of an emergency situation with service delivery or with a provider, the case manager will report all occurrences to the designated QM Specialist so the necessary intervention can take place.

Supplemental Support Services

Vermont does not intend to offer supplemental support services.

c. A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.

MFP Participants have several options for registering complaints about services or any other aspect of their care. Participants will be encouraged to work initially with their agency providers around areas where care has not been satisfactory. Whether or not participants choose to do that, complaints may be registered directly with the DAIL, the participant's case manager, or the Division of Licensing and Protection or Vermont's Long Term Care Ombudsman Office.

The Division of Licensing and Protection (DLP) enforces federal and state statutes and regulations for providers of health care and investigates cases of alleged abuse, neglect and exploitation of vulnerable adults. To report abuse, neglect or exploitation of a vulnerable adult or to enter a complaint against a facility or agency that provides health care, MFP participants can call DLP's toll-free hotline or download a reporting form from their website.

Vermont Legal Aid is a non-profit law firm established in 1968 to provide free civil legal services to Vermonters who are low-income, older adults and those with disabilities. Vermont Legal Aid established Vermont's Long Term Care Ombudsman Program, which was created to protect the health, welfare and rights of people who live in long term care facilities, including nursing homes, residential care homes and assisted living residences. It also helps people who receive long term care services in their homes through Choices for Care.

The Ombudsman Program improves Vermont's long term care system through individual complaint resolution, education and administrative and legislative advocacy. Ombudsmen are available to receive and investigate complaints that consumers and their guardians have regarding services rendered under the Demonstration, providing third party oversight of the program. They also serve as consumer advocates.

MFP QM staff will be responsible for investigating and resolving complaints received by DAIL. Complaints will be logged on the day received and assigned to a QM Specialist for disposition.

The QM Specialist will acknowledge all complaints in writing within one business day. Written complaints will receive a response within seven days.

The QM Specialist will prioritize complaints based on severity and work for their expeditious resolution. If a proposed resolution is not satisfactory to the participant, he or she will be referred to the MFP Project Director for further remediation. The final resolution will be provided to the participant in writing and will include a recitation of their right to file a request for a fair hearing before the Commissioner of DAIL.

All steps in the complaint resolution process will be recorded on the log. The logs will be reviewed as part of the demonstration's quality assurance activities.

A description of the complaint process will be drafted and included in the Choices for Care Participant Handbook provided to MFP participants. DAIL will use the complaint process as a training tool for all MFP staff to ensure all members of the Unit understand the importance of timely complaint resolution and the steps in place to ensure this occurs.

B.7 Self-Direction

Sub-Appendix I is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form will be made available to applicants.

Appendix G contains a copy of "Sub-Appendix I Self-Direction Submittal Form", as required by application instructions.

CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval. In addition to completing Appendix A, please respond to the following:

a. Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.

Vermont Self-Direction Background

As noted previously, the Choices for Care program offers three options to individuals who wish to self-direct their services and supports: consumer directed, surrogate directed, or the Flexible Choices Program. In the home-based setting, Choices for Care offers three services that may be directed by the individual (consumer-directed) or a surrogate employer: personal care; respite care and companion services. MFP demonstration participants will be afforded the same options to self-direct their services as other enrollees in Choices for Care. They also will follow the same process when electing to terminate self-direction in favor of an alternative service delivery method.

Participants in the Flexible Choices Program are assigned to a consultant who acts as an advisor to provide assistance with all aspects of the program. The consultants will have primary responsibility for facilitating termination of self-direction.

When a participant expresses a desire to terminate self-direction and selects an alternative service delivery method, the consultant or case manager will review the steps for giving notice to employees and transitioning to other service providers. The notice period (typically two weeks) will provide the consultant or case manager the necessary time to arrange for updating the care plan, notifying the state and initiating the replacement services. If the participant is leaving Flexible Choices, this will include transferring them from the consultant to a case manager in accordance with existing procedures.

A copy of the revised care plan will be given to the participant upon its completion. The consultant or case manager, through contact with service providers and follow-up calls to the participant, will assure that no interruption in services occurs. The participant will be monitored on a daily basis during the transition, through a combination of phone calls and in-person visits.

b. Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition

The state will involuntarily terminate individuals from consumer direction, surrogate direction or the Flexible Choices program for a variety of circumstances, including but not limited to: 1) the participant is no longer eligible for Choices for Care; 2) the participant or surrogate is not able to manage the requirements of being an “employer” or the requirements of the Flexible Choices Program; 3) the participant or surrogate commits fraud or otherwise inappropriately uses their resources; 4) the participant’s health, safety or welfare is at risk for any reason; or 5) the participant dies.

If the reason for involuntary termination has to do with a suspected change in cognition or inability to handle the program responsibilities, the consultant or case manager, prior to involuntary termination from either of the three self-direction options, will assess the member's cognitive ability and ability to communicate effectively using either the Employer Certification Form for consumer or surrogate direction. The final determination will be made by the case manager or consultant.

Once a decision is made to involuntarily terminate an individual from self-direction, the Flexible Choices consultant or Choices for Care case manager plans and implements the return of the participant to provider-managed services, if they are still eligible for Choices for Care.

Participants are re-assessed for their level of service needs and the care plan is updated to include the amount and type of provider-managed services required. The care plan is then reviewed with the participant and/or surrogate.

The case manager arranges all services in a timely manner so there is no gap or delay in service delivery. During this transition period, the case manager will assure that all services are delivered by remaining in close contact with both the participant and the provider agencies.

The participant's health and welfare will be monitored through phone calls, in-person visits to the participant, running late or missed visit reports, and re-assessing the participant as necessary. Any suspected cases of abuse, neglect, exploitation are reported to Adult Protective Services and DAIL's QM Department via the Critical Incident Reporting System procedures.

c. Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

Vermont's goal is to promote understanding and awareness of self-direction for all MFP demonstration participants. Transition Coordinators will address this option during the assessment process in the nursing facility.

Vermont's goal is to have 25 unduplicated participants in self-direction by year five of the demonstration. This would represent one-third of the unduplicated participant count of 75 projected for year five.

B.8 Quality

Provide a description of the State's quality Improvement system (QI S) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 365 day demonstration period. Regardless of the financing and/or service delivery structure proposed under the demonstration, states must demonstrate how services during the 365 day transition period will:

- *be utilized to inform the CMS evaluation of the state's MFP demonstration; and*
- *Meet or exceed the guidance for a QIS set forth in version 3.5 of the 1915(c) HCBS waiver application.*

Please follow the guidelines set forth below for completion of this section of the OP:

Description of Vermont's Quality Improvement System

DAIL is responsible for oversight and evaluation of Vermont's Quality Improvement System (QIS). The QIS is developed in accordance with specific waiver assurances and the Home- and Community-Based Services (HCBS) Quality Framework.

DAIL has developed a comprehensive program for monitoring the level and quality of services provided to Choices for Care participants. The program is designed to ensure the highest possible level of quality of care and enrollee satisfaction. This same quality structure will be used for MFP participants both during the demonstration year as well as after the 365 day demonstration period.

DAIL is aware that the MFP demonstration grant occurs within the state's overarching Quality Management Plan (QMP) for the existing waiver programs within the department. The QMP will be modified to reflect unique features of the MFP demonstration, including the transition payment, Quality of Life Surveys and CMS evaluation, so the appropriate quality monitoring can

take place. Adult Family Care, a new Qualified HCBS benefit, also will be addressed through the QMP.

DAIL received a Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services to develop a comprehensive Quality Assurance and Quality Improvement Plan for Choices for Care. Over the past ten years, the Real Choice Systems Change Grants have sought to increase consumer and family participation and direction of their Medicaid services.

Individuals who receive services, family members, service providers and DAIL staff formed the Quality Management Committee, which played a significant role in development of the QMP.

The primary objective for the QMP was to develop a quality management plan addressing all HCBS and to identify existing quality services and standards and quality management activities that are consistent with the CMS Framework. The second step was to identify and develop solutions for gaps within the current quality management system. As an outcome of this activity, new service standards that include quality in the design and delivery of services, a common set of quality indicators and language across waivers and a common set of quality indicators that incorporate the CMS Framework were developed to guide the delivery of service.

Since the completion of the Real Choices Grant, the QIS has been modified to focus more directly on specific programs. Modification of the current Quality Improvement System for Choices for Care has evolved into a program that follows the CMS Quality Framework, ensures

the quality of services delivered and ensures the health and safety of the participant. This same program will be in effect for MFP participants during the demonstration year and after the 365 day demonstration period.

The quality activities for the MFP program will be led by the two Quality Management Specialists assigned to the program. Their efforts will be supported by current quality staff assigned to the State Unit on Aging, which consists of a Manager and three Quality and Program Specialists. Reports of all quality related activities will be disseminated to DAIL's QI Committee.

The current QMP encompasses, or will encompass by the time the Vermont's MFP program is initiated, a range of activities that include, but are not limited to, the following:

- Review of functional assessments and level of care determinations
- Review and approval of all plans of care for demonstration enrollees
- Desk monitoring activities conducted by Long Term Care Clinical Coordinators (LTCCC), the individuals responsible for conducting level of care assessments and approving care plans for persons in home- and community-based settings
- Monitoring of services provided versus those included in the care plans
- On-site provider surveys
- On-site participant visits
- Ongoing case manager certification process
- Consumer satisfaction surveys

- Review and analysis of critical incidents
- Review and analysis of complaints
- Implementation of remediation activities

Consumer Satisfaction Survey - DAIL contracts with the University of Massachusetts for an annual consumer satisfaction survey based on a sample of recipients of home- and community-based care. DAIL will continue to administer this survey as part of the MFP demonstration in addition to the required CMS Quality of Life Surveys. To date survey results for Choices for Care show high levels of consumer satisfaction with the care received. While it is acknowledged that consumer satisfaction alone does not necessarily ensure that the care was of high quality, it is an important indicator.

Review and Approval of all Plans of Care and Certification of Case Managers - DAIL staff (LTCCC) review and approve all plans of care for Choices for Care participants and any subsequent changes to those plans. This ensures consistent approaches to care plan development and the allocation of resources. Additionally, all participants have a designated case manager. The case managers must have a face-to-face visit with their assigned enrollees at least once a month and more frequently if necessary.

Case managers are professionals who are certified after the receipt of training, the completion of required supervised practice hours and the demonstration of competent practice. Certification remains in effect unless revoked due to clear evidence that quality case

management services, consistent with DAIL Case Management Standards, are not being provided.

Tracking of Services Actually Provided - DAIL monitors the quantity of services provided to participants versus those listed on the care plan. This ensures that the oversight agency knows what portion of the services included on the care plan was actually provided. For a variety of reasons, it is unlikely that 100 percent of the services listed would be provided, but a significant portion should be delivered. In instances where an issue is identified by the state, DAIL staff will follow-up with the responsible agency. A system for electronically tracking and trending this information, by participant, is being developed.

Local Waiver Teams

Under the MFP demonstration, as with the larger Choices for Care system, local Waiver Teams will continue to provide significant oversight of the program. There are thirteen Waiver Teams throughout the state. These teams are comprised of case managers from the regional home health agencies and Area Agencies on Aging, as well as representatives of adult day centers, local Department for Children and Families/Economic Services Division offices, hospital discharge planners/social workers, residential care homes, assisted living residences and nursing facility social workers. Other providers, such as the Designated Agencies, join the teams as needed.

The teams meet monthly and review all active cases. Cases that involve outstanding issues are thoroughly discussed and alternative solutions or care approaches are reviewed. Under the demonstration, LTCCCs will continue to facilitate the Waiver Teams, and provide technical assistance and updates about any changes in policies and procedures. Transition Coordinators will participate on the teams as appropriate.

Oversight of Home Health Agencies/Residential Care Homes/Assisted Living Residences/Adult

Day Centers - Much of the care provided to MFP demonstration participants will be furnished by home health agencies located throughout the state. These agencies are subject to state and federal regulations and are regularly surveyed by the DAIL Division of Licensing and Protection. The inspections include a review of the quality assurance and quality management activities and functions of the agency. DAIL also provides direct oversight of the residential care homes/assisted living residences in the state through its licensing and surveying responsibilities. DAIL certifies all Adult Day Centers that receive state and/or federal funds are meeting the state standards.

Checks and Balances in the Provider System - Many MFP demonstration participants will receive services from multiple providers, including home health agencies, Area Agencies on Aging, adult day centers, respite service providers, transportation providers and individual attendants. The involvement of multiple provider organizations helps to ensure a series of checks and balances in the system because all of these providers are mandated by law to report

any actual or suspected abuse, neglect or exploitation. It also works to ensure that at least one provider will pick up on a situation that may be a precursor to future problems for the enrollee.

Other Quality Monitoring Activities - DAIL also conducts a variety of other monitoring activities to ensure quality of care. These include monitoring of grievances and appeals, nursing facility admission and re-admission rates to acute or long-term care facilities for participants, DAIL interviews with consumers, and changes in the functional status of enrollees based on their need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The expansion of the Long-Term Care Ombudsman program to include home-based care also adds an important new element to monitoring efforts. Additional monitoring activities are performed through the complaint line staffed by the DAIL Division of Licensing and Protection and through investigations by Adult Protective Service investigators.

a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

The state need not provide documentation of the quality management system already in place that will be utilized for the demonstration. But, rather provide assurances in the OP that:

- i. This system will be employed under the demonstration; and*
- ii. The items in section (C) below are addressed.*

In addition, the state should provide a brief narrative regarding how the existing waiver QIS is already or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.

The above section does not apply to the Vermont MFP demonstration.

b. If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), State Plan Amendment, or 1115) will address the items in section (c) below.

Vermont plans to integrate the MFP demonstration into its existing 1115 waiver program to serve individuals during and after the MFP transition year. Vermont will rely significantly on existing infrastructure to ensure that the MFP demonstration is operated in compliance with federal waiver assurances. DAIL also will conduct additional oversight to assure the demonstration complies with federal assurances and other federal requirements.

Participants in the MFP demonstration will be served within the same case management, provider and oversight system as other Choices for Care enrollees. Vermont therefore can assure that the MFP demonstration will incorporate the same level of quality assurance and improvement activities required under the waiver program during the individual's transition and for the first year the individual is in the community.

As detailed in the description of Vermont's Quality Improvement System above, we have developed and will continue to enhance the existing QMP framework to ensure the quality of services delivered and the health and safety of participants in the MFP demonstration. Along those lines, the current delivery structure will address the waiver assurances articulated in version 3.5 of the 1915(c) waiver application as detailed in section (c) below upon implementation of the MFP demonstration.

c. The Quality Improvement System under the MFP demonstration must address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application and include:

- i. Level of care determinations;
- ii. Service plan description;
- iii. Identification of qualified HCBS providers for those participants being transitioned;
- iv. Health and welfare;
- v. Administrative authority; and
- vi. Financial accountability.

Below is a sampling of 1915(c) HCBS waiver assurances taken from version 3.5 of the 1915(c) HCBS waiver application: level of care determinations; service plan description; identification of qualified HCBS providers for those participants being transitioned; health and welfare; administrative authority; and financial accountability. For each waiver assurance, we have included a desired outcome as well as a narrative description of how Vermont will meet each of the outcomes.

i. Level of Care Determinations

a.i.a Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
a.i.b Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
a.i.c Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Desired Outcome: One-hundred percent of MFP participants will have a level of care evaluation annually.

DAIL Long Term Care Clinical Coordinators (LTCCCs) will perform level of care assessments on all waiver participants and make all level of care determinations using the state’s pre-admission screening instrument, known as the Clinical Eligibility Worksheet. The current process consists

of a review of assessment documents and follow-up phone calls and face-to-face interviews with applicants, as necessary.

With the state staff making the initial level of care determinations, DAIL ensures a more consistent application of the standards used for decision-making. The overall objective of the DAIL clinical oversight processes is to ensure that the services included in care plans are appropriate, both in scope and volume, relative to the identified needs of the individual participants in the demonstration.

Periodic review by the DAIL central office staff of the LTCCCs determinations is in place. This practice provides a second level “check and balance” system for the oversight of LTCCC decisions. Level of care is reevaluated on an annual basis.

ii. Service Plan Description

a.i.a Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
a.i.b Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.
a.i.c Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.
a.i.d Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

Desired Outcome: Services and supports are planned and delivered in accordance with each participant's unique needs and preferences.

Case managers use the results of the Independent Living Assessment as the basis for the development of the individual's plan of care (service plan). Based on the assessment, the individual's circumstances, resources, program eligibility, and formal and informal support systems are reviewed. The case manager also conducts a review of service options and discusses any limitations with the individual and/or their representative. The case manager will, in conjunction with the individual or his/her representative, develop an individualized care plan that includes an array of services based on data from the comprehensive assessment and appropriate to the needs and preferences of the individual.

The comprehensive care plan will also include a back-up care plan in the event of an emergency. The plan will specify not only the services to be provided, but also the quantity in which they are to be provided and the provider designated to deliver each service. Participants and/or their representatives will be encouraged to participate in the care plan development process. The participant and his/her representative will also sign off on the care plan.

The assessment and plan of care are updated at least annually and more often if warranted by changes in the participant's situation or condition. The enrollee is considered to be an active participant in the care planning process and will be notified of any modifications to his/her plan. The case manager will also conduct a review of any new or more appropriate service

options that should be considered with the participant or their representative. The participant will review and sign-off on the revised service plan. The completed re-assessment and signed service plan will be sent to DAIL for a staff level review.

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

DAIL monitors the contents of care plans and compares the actual utilization of services by the participant to those services included in the care plan. Other standard monitoring practices include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, resolution, and data analysis.

Comparative analyses are periodically conducted across the plans of care developed by the Area Agencies on Aging versus those prepared by the home health agencies. These comparisons examine the degree of variability among the plans across like populations. Where plans are deemed to be inadequate, a corrective action plan is required and closer monitoring done specific to the individual case manager. The DAIL database is used to further assess the content of the care plans. This system enables the Department to compare and contrast the care plans developed by different agencies across like populations.

iii. Identification of Qualified HCBS Providers for those Participants being Transitioned

a.i.a Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
a.i.b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
a.i.c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Desired Outcome: There are sufficient service providers for the MFP demonstration and they are qualified by licensing, certification, or state regulations.

All participating providers are required to meet DAIL’s licensing and certification requirements or established standards. DAIL has the primary responsibility for ensuring appropriate licensure and certification of all providers. The DAIL central office is responsible for monitoring provider status. Non-licensed, non-certified providers are also required to meet certain standards established by DAIL. For example, all consumer or surrogate directed employees must pass a

background check and may no longer provide care to consumers if they have a disqualifying finding. Any provider found to be out of compliance will be notified of the required corrective action to continue as a demonstration provider.

All case managers must be certified according to the state's procedures, as previously described. Certification remains in effect unless revoked by DAIL or the case management agency. Revocation will occur when there is clear evidence that quality case management services, consistent with DAIL Case Management Standards, are not being provided and/or professional development and training has not been maintained. If a determination is made that an individual case manager is not otherwise performing up to state standards, a discovery and remediation system is activated.

iv. Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation

Desired Outcome: Participants are safe and secure in their homes and communities.

On the first day of transition, each MFP participant will have a risk mitigation plan, a 24 hour backup plan in place, and a system to report critical incidents. Within six months, the critical incident reporting system will be in place and fully operational to monitor these processes. A summary of these three components is presented below.

24-Hour Back-up System - The first level of backup for all MFP participants will be identified as part of their care plan (the backup plan) and include at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. The plan also will include a list of emergency contacts.

The second level of back-up will be the assigned case manager/case management agency. If the back-up provider on the care plan is not able to resolve the issues for the participant, the case manager (or his/her agency) will be contacted for assistance. Case management agencies are required to offer 24-hour telephone access through an answering service or other means. As a further safety measure, DAIL also plans to contract with Vermont 211 to provide 24 hour backup services for MFP participants, as noted in Section B.6. Consumer Supports. Vermont 211 will provide access to live representatives 24 hours/day, 7 days per week who can draw on resources to meet the needs for critical services and supports. DAIL will be responsible for overseeing the system and will require reports on all calls to monitor responsiveness and timeliness.

DAIL will train VT-211 on all aspects of MFP as well as provide phone numbers to which callers can be referred. MFP participants will be provided with information on the 24 hour backup services in their participant handbooks so they know who to call. MFP QM Specialists will monitor the back-up response system to ensure emergency services are provided timely.

Risk Assessment and Mitigation Process - Transition Coordinators will complete transition assessments on all MFP participants prior to their discharge from a nursing facility. The transition assessment will identify potential risks in transitioning to the community, including situational, environmental, behavioral, medical and financial.

The Transition Coordinator, in collaboration with the participant and the participant's assigned case manager, will develop a care plan. The care plan will identify and document strategies to address the risks identified in the transition assessment as well as an emergency backup plan. Upon completion of the care plan, a copy will be provided to the participant. Care plans will be implemented and monitored by the participant's assigned case manager. The assessment and care plan will be updated at least annually and more often if warranted by changes in the participant's situation or condition.

DAIL clinical staff (LTCCCs) will conduct a thorough utilization review prior to authorizing any modifications to the plan. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals.

They will ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained. They also will monitor, directly or indirectly, the delivery of services

under the care plans and track the proportion of services included in the plan that are actually delivered to the enrollee.

Critical Incident Reporting System - Vermont will ensure appropriate action is taken to address or remediate critical incidents. A “Critical Incident” is any actual or alleged event, incident or course of action involving the perceived or actual threat to an MFP participant’s health and welfare or his/her ability to remain in the community.

Essential to this endeavor will be the ongoing development and implementation of a robust critical incident reporting system to enable MFP staff and DAIL’s QI Committee to:

- Analyze the type and number of complaints from a systemic level
- Look for trends by area and service provider
- Identify statewide issues
- Develop and implement plans for improvement

One element of DAIL’s Quality Improvement Program is the critical incident reporting and management system. Critical incident reporting provides DAIL with data needed to identify and evaluate systemic problems, and to address problems experienced by provider agencies.

Contracted service providers who deliver services to participants, Transition Coordinators, case managers, and any person who becomes aware of a critical incident are required to report the following critical incidents or events to DAIL in the form of an incident report:

- Allegations or suspicion of abuse, neglect or exploitation of a vulnerable adult

- Untimely death of a person
- Missing Person
- Use of a Restraint
- Unexpected hospitalizations
- Injuries requiring medical treatment
- Events or incidents that cause harm to MFP participants or serve as indicators of risk to participants' health and welfare
- Other critical incidents such as a fire, theft or destruction of property, criminal act or unusual events.

DAIL will be the responsible state agency for overseeing the reporting of and response to critical incidents for MFP participants. In this capacity, DAIL will be responsible for all of the following:

- Developing and implementing an internal incident reporting and management system;
- Implementing procedures to address identified risks;
- Training Transition Coordinators, case managers, DAIL staff and its contractors, providers, participants and the general community on its critical incident reporting system and processes;
- Evaluating provider agency response to incidents;
- Providing technical assistance to providers;
- Maintaining an incident report database;
- Producing reports related to the information collected; and

- Analyzing incident report data as a risk management tool and develop a plan of action to prevent reoccurrences

DAIL also is beginning an initiative in SFY 2012 with the Albany College of Pharmacy whereby advance practice students will be reviewing medications of Choices for Care participants referred to them for appropriateness and contraindications. MFP participants will be one of the initial target populations to be monitored under this initiative.

Training

MFP Transition Coordinators, in collaboration with Quality Management Specialists, will train case managers, DAIL staff and its contractors, providers, participants and the general community on DAIL's critical incident reporting system and processes. Training will be tailored to each audience and will include, but not be limited to, such topics as: abuse, neglect and exploitation; how to complete DAIL's incident report form; the types of critical incidents; the investigation and remediation process; reportable incidents; and responsible entities.

In addition to providing training, DAIL representatives will conduct oversight of staff and contracted providers to ensure critical incident reporting policies are being followed.

Corrective action will be taken as needed to ensure these entities comply with critical incident reporting requirements.

Critical incidents will be monitored on a case-by-case basis to assure timely, adequate and complete resolution. In light of this, DAIL will dedicate one Quality Management Specialist to be

the responsible entity to review critical incident reports and act upon them if individual remediation and/or system improvement is needed. The critical incident reporting process will be the same for all MFP and Choices for Care waiver participants. DAIL's QI Committee will be the responsible entity that will oversee and verify that processes were followed and appropriate actions were taken.

Critical Incident Reporting

Contracted service providers, Transition Coordinators, case managers, and any person who becomes aware of a critical incident will be required to complete DAIL's incident report form (a copy of the form is included in Appendix H). The person completing the form will send it to DAIL's MFP QM Specialists by fax, electronically (accessible via the DAIL's website) or in person no later than 24 hours from the critical event. While an initial verbal report is allowable, a written report is required within 48 hours of the incident.

DAIL's Incident Reporting process does not substitute for the reporting requirements of other agencies. Harm to vulnerable individuals must be reported to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Program Integrity Unit for follow-up.

DAIL will ensure a process is in place to protect the participant pending completion of a review/investigation. Each process will depend on the individual circumstance as it relates to the incident and may include more intensive case management, revising the participant's care plan and backup plan to substitute or add services, frequent site visits to the participant's qualified residence and/or reassessment of the participant's needs.

In addition to the formal incident reporting process, DAIL program standards require case managers to have at least monthly contact with participants. This practice helps instill a degree of confidence in the safety and welfare of the participants. Case managers also are responsible

for assessing risk during the initial assessment, on an annual basis and as needed in the event of a status change. Care plans and emergency backup plans are revised as necessary to factor in any new levels of risk.

Investigation

DAIL's QM Specialists will respond to each incident based on individual need and significance. The QM Specialists will date stamp all reports upon receipt and enter report information into the critical incident database. Copies of all incident reports will be maintained in the MFP participant's file and reviewed as part of the MFP Quality Assurance process.

If the critical incident involves a contracted provider or subcontractor, the designated QM Specialist will require the provider to conduct an internal critical incident investigation and submit a report on the investigation. The QM Specialist will review the report and ensure that appropriate interventions were taken. If an adequate response was taken, no further action will be necessary.

However, for an inadequate response, the MFP Project Director will be notified and will contact the provider to discuss the areas in which the response was found to be inadequate. The Project Director may request a Critical Incident Improvement Plan and will notify the QM Specialist that a plan has been requested.

Complaints of abuse, neglect and exploitation will be referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Program Integrity Unit for follow-up as appropriate or as required by Vermont Statute.

For all other critical incidents, the DAIL MFP QM Specialists will investigate through a multidisciplinary review that involves key stakeholders involved in the incident. The investigation will incorporate the following information:

- Circumstances leading up to and culminating in the critical incident;
- Any current practice, procedure or factor involved in providing the service that contributed to the occurrence of the critical incident;
- Actions considered, developed or required as follow up to the critical incident; and
- Implementation of any recommendations resulting from the critical incident review.

Remediation

The appropriate action will be taken to resolve the critical incident and a Critical Incident Improvement Plan will be developed. If the critical incident involves a contracted provider or subcontractor, the involved entity, in consultation with QM Specialists, will develop a plan which addresses the actions to be taken to prevent reoccurrences, or to improve response in the event of similar incidents, a date by which the actions will be taken, and the provider agency staff responsible for taking the actions.

The provider will submit the plan to the QM Specialists upon completion. The designated QM Specialist will monitor the progress of the plan by following up with the appropriate provider or entity to obtain timely receipt of the plan and to assess the adequacy of its implementation. Feedback/direction will be provided to appropriate stakeholders to implement quality improvements as required.

During any review, when DAIL encounters situations in which a participant's health and welfare are at risk, staff will follow a protocol to report the observation and ensure the health and welfare of the participant. Operating agencies are required to respond with a corrective action plan depending on the severity of the situation.

DAIL contracts with Vermont Legal Aid for Long Term Care Ombudsman services for all individuals served through the program. This will ensure that all program participants have access to an independent entity responsible for representing their interests.

All critical incidents will be reported to DAIL's QI Committee, which will be the responsible entity for verifying that required processes were followed and appropriate actions were taken. The Committee also will review findings to determine whether additional follow-up is required and to identify any necessary system adjustments or best practices.

The QI Committee will review reports that are generated by the incident report database to identify trends that may need to be responded to by remediation and to identify improvement

activities. The QI Committee will review the adequacy of the response to the critical incident report and determine the closure of reports. Remediation is assured and tracked on a case-by-case basis.

Critical Incident Tracking and Quality Assurance

The QM Specialists will maintain an incident report database to track incidents; monitor technical assistance and dispositions (including requests for additional information regarding incidents and status of Critical Incident Improvement Plans); and conduct tracking and analysis of critical incident trends.

Reports will be run quarterly and reviewed to ensure that appropriate action was taken at the time of the incident. Reports will be provided to DAIL's QI Committee and reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate and/or prevent any recurrence of the incident. Following is a list of data elements that will be tracked for MFP participants:

- Number and type of reportable critical incidents, by type;
- Average (mean/median) number of critical incidents per waiver participant;
- Number and percent of critical incidents requiring investigation, by type;
- Number and percent of critical incidents substantiated, by type;
- Number and percent of critical incidents investigated within required timeframe;

- Number and percent of critical incidents for which corrective actions were verified within required time frame; and
- Number of waiver participant deaths from unexplained or suspicious causes

v. Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Desired Outcome: The system operates the MFP waiver program effectively and ensures a comprehensive quality structure is in place.

DAIL and the Department of Vermont Health Access (DVHA) are both departments within the Vermont Agency of Human Services. As Vermont’s Medicaid agency, DVHA retains ultimate administrative authority and responsibility for the operation of the waiver program. DAIL will be responsible for day-to-day administration of the MFP demonstration. This is the same structure as employed for the Choices for Care waiver.

vi. Financial accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Desired Outcome: MFP claims are coded and paid are in compliance with waiver requirements.

AHS will ensure through its Medicaid Management Information System (MMIS) and its claims processing contractor (Hewlett Packard) that there is no duplication of payments for services

rendered through the various Medicaid waivers and programs. The MMIS contains logic to identify duplicate claims, regardless of the funding source/program, thereby preventing duplication of payment.

The MMIS maintains a “Demographic Modifier” table that is used to match Medicaid enrollees to specific programs, including the Choices for Care 1115 Waiver. The Demographic Modifier table includes the recipient ID and the start/end dates for enrollment in these specific programs. The Demographic Modifier logic enables the system to assign payment responsibility to a specific funding source, as well as maintain other edits.

For non-MMIS services, the state relies on a number of other reporting and monitoring tools to prevent duplicative payments. The Medicaid program and DAIL also have policies and procedures to ensure that financial reporting and monitoring for non-Medicaid funded programs, such as the Older Americans Act, are coordinated with Medicaid funded programs.

The Medicaid Provider Participation Agreement prohibits providers from billing Medicaid (as the payor of last resort) for any service that has been reimbursed or funded by another source. The state’s Medicaid Program Integrity Unit monitors compliance with this requirement through periodic claims reviews and provider audit activities.

Oversight and monitoring of the Intermediary Service Organization (ISO) for employer support services within the consumer and surrogate-directed services program is conducted via monthly meetings and through data submission and claims review.

d. If the State provides supplemental demonstration services (SDS), the State must provide:

- 1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,*
- 2. A description of the remediation and improvement process.*

Vermont is not proposing to offer supplemental demonstration services.

B.9 Housing

a. Describe the State’s process for documenting the type of residence in which each participant is living (See chart for examples in Sub-Appendix II). The process should categorize each setting in which an MFP participant resides by its type of “qualified residence” and by how the State defines the supported housing setting, such as:

- i. Owned or rented by individual,*
- ii. Group home,*
- iii. Adult foster care home,*
- iv. Assisted living facility, etc. (Please see the Policy Guidance in Sub-Appendix VI)*

Vermont will secure housing for MFP participants in a “qualified residence” as defined in Section 6071 (b)(6) of the Deficit Reduction Act. There will be four types of qualified residential settings from which MFP participants can choose:

1. A home owned or leased by the individual or the individual's family member; this option is not regulated by the state and the lease is maintained with the landlord or owner.
2. An apartment with an individual lease is a residential type that can be in an apartment building, assisted living facility, and/or public housing unit. The apartment will have lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control. Apartments are regulated. An apartment building is regulated by the lease and held by the landlord. An assisted living facility is regulated by the state, and public housing units are regulated through Section 8 by the Vermont State Housing Authority.

3. A residence, in a community-based residential setting, in which no more than four unrelated individuals reside. These types of community based settings can include: group homes (not applicable to MFP) and Residential Care (including enhanced residential care). These two types of community based alternative residential settings are regulated by DAIL, Division of Licensing and Protection.
4. A residence, in a community based residential setting, in which one or two individuals unrelated to the caregiver reside. These will all fall under the category of Adult Family Care homes. They will be required to meet health and safety standards established by DAIL and will be monitored regularly by Community Development staff and case managers. They will not be formally licensed by DAIL's Division of Licensing and Protection, however.

Transition Coordinators in coordination with Community Development Specialists will discuss all housing and service options with participants. The participant or his/her authorized representative must approve the selection of the qualified residence in which the individual will reside. Once the decision is made, the Transition Coordinator will document the type of residence where each participant chooses to live in the participant's transition plan.

Transition Coordinators will submit transition plans to DAIL that include the choice of housing at least 30 days prior the transition. Information on the type of qualified residence that the individual chooses must be verified and approved by DAIL prior to the individual's discharge from the nursing facility. Verifications may be made through a visit to the residence, a report of

the consumer or representative, information obtained from the property manager or landlord, licensure information or information from a local housing authority.

Approval will be given in writing and will become part of the participant's file. Information about the community residence chosen by each participant will be documented and reported to the state and CMS using the report format presented in Sub- Appendix II of the application instructions.

Once the individual is enrolled in the MFP demonstration, the participant's case manager will be responsible for monitoring and reporting any changes in the participant's qualified residence. The case manager will report this information to DAIL for tracking purposes using a "Change in Status Form".

b. Describe how the State will plan to achieve a supply of qualified residences so that each eligible individual or the individual's authorized representative can choose a qualified residence prior to transitioning.

i. Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions;

Transition to a community residence will be dependent on having a sufficient supply of qualified residences in the service area of the potential participant. Keeping in mind the projected number of MFP participants each year and the fact that the program encompasses the entire state of Vermont, this will require a concerted effort between the Agency of Human Services, DAIL, Division of Licensing and Protection, Vermont Housing and Conservation Board, Vermont Public Housing Authority and other partnering organizations.

Under MFP, Community Development Specialists will be contracted by DAIL to identify and coordinate housing options for persons moving out of nursing facilities into the community. An inventory of available qualified residence options will be developed by the Community Development Specialists to assist Transition Coordinators and participants with community placement.

Community Development Specialists also will disseminate housing information to other stakeholders in the community setting, such as families, caregivers, guardians and advocates. They will conduct outreach to build capacity, particularly for the new Adult Family Care housing option and will participate in housing workgroups and work with housing agencies to address supply issues.

ii. Explain how the State will plan to address any identified housing shortages for persons transitioning under the MFP demonstration grant:

Community Development Specialists will work on a routine basis to expand housing options and capacity in their assigned geographic areas. If a shortage emerges, outreach and recruitment efforts will be intensified, including through temporary placement of additional MFP staff to aid in recruitment activities. Community Development Specialists also will foster relationships with town officials and housing providers and organize ad hoc housing work groups to address specific needs. They will ensure that placement options requiring environmental modifications are not overlooked as part of the recruitment process.

In addition, Community Development Specialists will consult with their counterparts in the area responsible for recruiting providers to operate Developmental Disabilities Services (DDS) homes. These residences are similar to Adult Family Care homes and the Developmental Disabilities Services component of DAIL has extensive experience devising strategies to address shortages in DDS Home capacity when they occur.

iii. Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and

As discussed above, Vermont is moving forward with the addition of a new Qualified HCBS option, the Adult Family Care Home. This alternative residential setting will increase the capacity of affordable/accessible housing options for the older adults and physically disabled residents in Vermont and will be available both to MFP participants and other Choices for Care enrollees. However, Vermont is aware that, like in most other states, the lack of affordable/accessible housing poses one of the greater challenges to rebalancing the long term care system.

DAIL is, and will continue to work with housing authorities throughout the state on expanding housing options and capacity. This will occur through the ad hoc MFP committee, which was originally created by DAIL to explore new housing options and has played a leading role in defining the Adult Family Care benefit. DAIL's partners in this effort include but are not limited to the Office of the LTC Ombudsman, Area Agencies on Aging, the Vermont Center for Independent Living, the Vermont Housing and Conservation Board, the regional office of the

Department of Housing and Urban Development and the Vermont Coalition for Disability Rights.

iv. Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants:

Vermont recognizes that working in partnership with housing professionals is essential to assuring a supply of accessible and affordable housing options. We also understand from CMS training sessions that there is a definite link between housing availability and MFP participant ability to meet transition targets. This recognition was the impetus for the state's decision to identify the role of the Community Development Specialists described above and add Adult Family Care as a Qualified HCBS benefit.

The state is confident its strategy will expand affordable and cost effective housing options over the life of the demonstration. A portion of the savings achieved may be used to increase reimbursement for adult family care providers who specialize in serving participants with particularly complex needs, as a way to further increase capacity.

B.10 Continuity of Care Post Demonstration

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:

a. Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:

- i. 1915(b) waivers and managed care contracts are amended to include the necessary services*
- ii. appropriate HCBS are ensured for the eligible participants; or*
- iii. A new waiver will be created.*

MFP participants will not be transitioning into a 1915(b) waiver as part of this demonstration.

b. Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:

- i. capacity is available under the cap;*
- ii. A new waiver will be created; or*
- iii. There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915(c) waiver.*

MFP participants will not be transitioning into a 1915(c) waiver as part of this demonstration.

c. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:

- i. Slots are available under the cap;*
- ii. A new waiver will be created; or*
- iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver*

Vermont plans to continue all Qualified HCBS benefits after the MFP demonstration.

Participants in the Vermont MFP demonstration will receive home- and community-based services through the existing 1115 demonstration program, Choices for Care, and will therefore experience no interruption at the end of their participation in the demonstration.

Unlike some other Section 1115 waivers, Choices for Care does not have a cap on HCBS slots. Enrollees in the Highest and High Need categories (which include nursing facility residents) are entitled to choose between HCBS and nursing facility care. High Needs individuals are served to the extent funding is available. Therefore it will not be necessary to reserve slots for MFP participants through an amendment to the waiver.

d. State Plan and Plan Amendments - for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no disruption of services when transitioning eligible participants from the demonstration program

State plan optional services will not be used for Vermont's MFP demonstration.

C. PROJECT ADMINISTRATION

Provide a description of the day to day organizational and structural project administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:

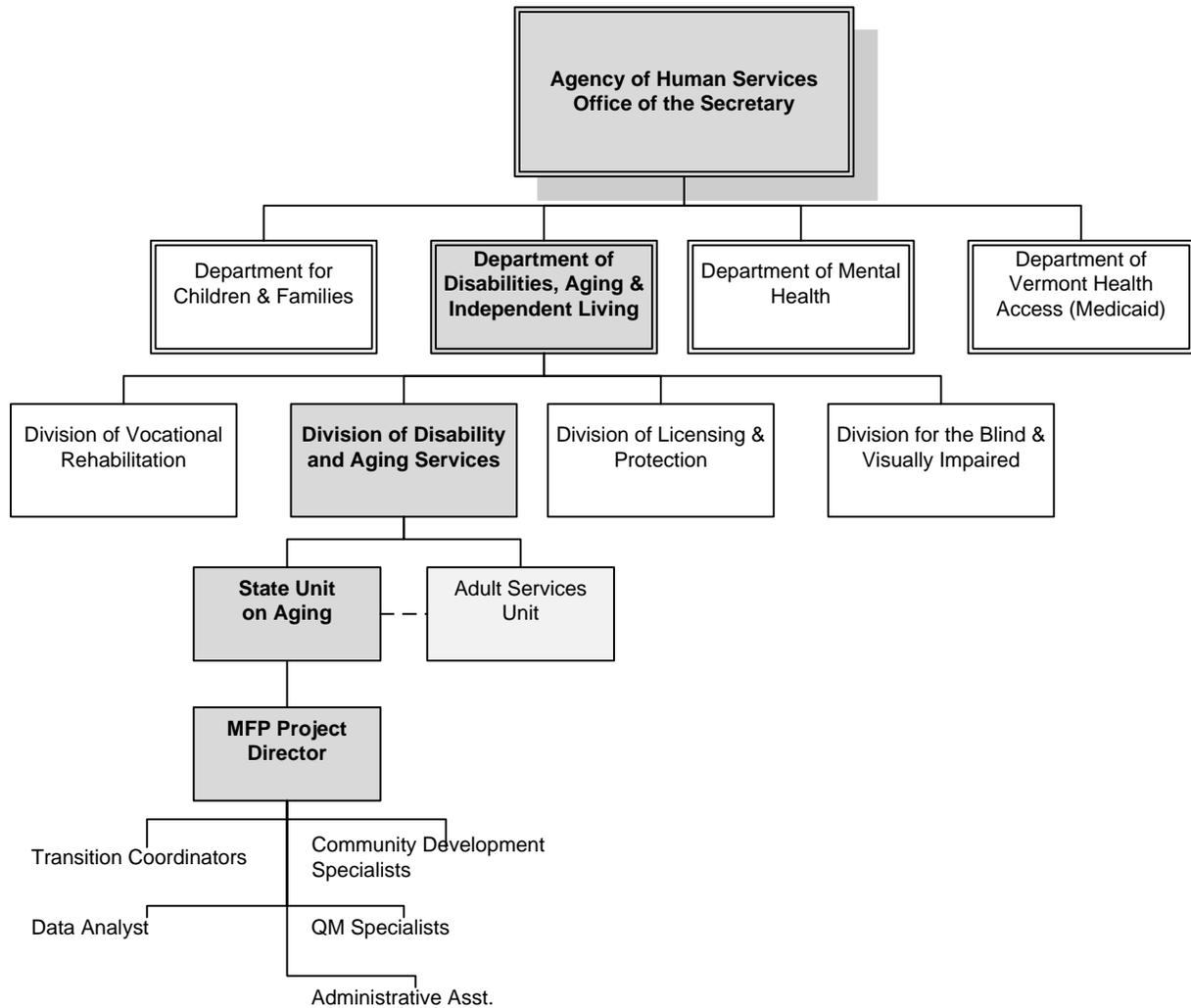
1. Organizational Chart: Provide an organizational chart that describes the entity that is responsible for the day to day management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and supports and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.

The Department of Disabilities, Aging and Independent Living (DAIL), within the Agency of Human of Services (AHS) will be responsible for day-to-day management of the grant. DAIL will operate the MFP demonstration from within the State Unit on Aging. DAIL already oversees all aspects of the Choices for Care waiver, and will manage MFP as a fully integrated component of the waiver.

DAIL will coordinate activities with the state's Medicaid agency, the Department of Vermont Health Access (DVHA), which is also located within AHS. DAIL and DVHA work closely together today on administration and reporting activities for Choices for Care.

Other partner agencies residing within AHS include the Department for Children and Families/Economic Services Division (DCF/ESD), which is responsible for financial eligibility determination and the Department of Mental Health. Exhibit 11 below presents the organizational structure for administration of the demonstration. (This is identical to the structure shown in Exhibit 2.)

Exhibit 11 – Demonstration Organizational Structure



2. Staffing Plan: Provide a staffing plan that includes:

a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director’s resume or Job Description including performance evaluation criteria (CMS pays 100% of the cost of this position, CMS will have input into the approval of the person hired. At any time CMS feels that the individual is not performing up to our expectations, CMS may request that a new Project Officer be assigned.)

Camille George, Director of the Division of Disability & Aging Services for DAIL, will serve as the Interim Project Director for this demonstration and will have day-to-day responsibility for the

operation of the project until a permanent position is filled. DAIL assures that the Project Director will be a full-time position and CMS will have input into the approval of the person hired. A job description for the Project Director position is located in Appendix I.

- b. The number and title of dedicated positions paid for by the grant and a justification of need. Please indicate the key staff assigned to the grant, if they have been identified.*
- c. Percentage of time each individual/position is dedicated to the grant.*
- d. Brief description of role/responsibilities of each position.*

Vermont's MFP staffing plan includes a funding request for 7.5 FTE staff positions to be dedicated solely to demonstration activities. The state is making a significant staffing commitment in recognition of the complex needs and challenging nature of the population being targeted for transition back to the community. The plan also takes into account Vermont's largely rural population and the need to have field-based staff located throughout the state.

The number and title of dedicated positions, percentage of time each individual is dedicated to the grant, brief description of roles/responsibilities and a justification of need are presented in Exhibit 12 below.

Exhibit 12 – Vermont MFP Staffing Plan

FTEs	Title	% of Time	Roles/Responsibility	Justification of Need
1	Project Director	100	The Project Director is responsible for leading the design, development, implementation and plans for sustaining the CMS MFP demonstration. Also oversees training activities	CMS required position; CMS pays 100% of the cost of this position
0.5	Administrative Assistant	100	A half-time clerical position to support the Project Director, the Steering Committee and workgroups	Position is a new hire dedicated to the project; therefore 100% federal funding is requested
3	Transition Coordinators	100	Identify candidates for MFP demonstration; respond to nursing facility referrals; perform transition planning and transition assessments in nursing facilities; communicate potential enrollee information to case managers and work with case managers to develop a care plan and to identify and coordinate specialized supports; work with community development specialists to arrange housing options; and provide transition follow-up as necessary to support the participant and case manager	Positions are new hires dedicated to the project; therefore 100% federal funding is requested
1	MFP Data Analyst	100	Receive and collate documentation for clinical review and approval; perform data collection, analysis and complete required MFP reports; develop and update the MFP portion of DAIL’s website; assist quality staff to manage program tracking systems	Position is a new hire dedicated to the project; therefore 100% federal funding is requested

FTEs	Title	% of Time	Roles/Responsibility	Justification of Need
2	QM Specialists	100	Oversee 24/7 back-up system, critical incident and reporting system, and risk mitigation programs; perform all required QM and utilization review activities; assist with independent evaluation as necessary; assist in writing the operational protocol and analyzing data related to the demonstration; manage all requirements related to internal, state and federal reporting, tracking, and data management, including management of MFP benchmarks; oversee certification and licensure reviews of clinical staff and housing; interface with CMS and DAIL on integrity of required data systems; grant financial and performance reporting	Positions are new hires dedicated to the project; therefore 100% federal funding is requested

e. Identify any positions providing in-kind support to the grant.

At the present time, due to the nature of the work intensity required for this project, there will not be any existing positions providing in-kind support to the grant.

f. Number of contracted individuals supporting the grant.

Two Community Development Specialists will be contracted to assist in identifying qualified residences for MFP participants and developing strategies for increasing available affordable and accessible housing. The Community Development Specialists also will participate in housing workgroups and forums; develop and perform community outreach & marketing across the state; develop a comprehensive list of transportation and other supportive assistance options; perform referral support functions; and support training initiatives. The state believes the expertise to provide this service can best be obtained through competitively bid contracts with organizations devoted to expanding housing options for the state's vulnerable populations.

Vermont also will contract with organizations that do not act as direct service providers to serve as consultants to Transition Coordinators. These will likely include a combination of the Vermont Center for Independent Living, Area Agencies on Aging, Designated Agencies, State Independent Living Council, HomeShare Vermont and other local organizations familiar with Vermont's supportive home- and community-based services.

Exhibit 13 below summarizes the key responsibilities of the hired and contracted positions, and illustrates how they will interact with each other and with participant case managers.

Exhibit 13 – Vermont MFP Staff Responsibilities and Interactions

Outreach and Market Development	Identification of MFP Candidates	Transition Planning	Service Planning	Service Delivery
Transition Coordinator	Transition Coordinator	Transition Coordinator		
Meet with nursing facility discharge planners on monthly basis	Meet with member and member's family. Perform transition assessment	Facilitate transition planning, including meetings with member and family, Community Development Specialist, MFP consultants and Case Manager. Also assist with training activities		
Community Development Specialist		Community Development Specialist		
Ongoing activities to identify and expand housing options		Identify housing options and assist member with reviewing options and selecting new home. Also assist with training activities		
		Case Manager	Case Manager	Case Manager
		Participate in transition planning	Responsible for care planning and oversight	Ongoing communication. Ensure service delivery in accordance with care plan
QM Specialist and Data Analyst	QM Specialist and Data Analyst		QM Specialist and Data Analyst	
Monitoring of service capacity and program awareness	Monitoring of compliance with MFP Operational Protocol and Performance Benchmarks		Evaluate performance data (compliance with care plan, satisfaction)	

g. Provide a detailed staffing timeline.

Camille George, Director of the State Unit on Aging, will serve as the Interim Project Director for this demonstration and will have day-to-day responsibility for the operation of the project until a permanent position is secured. The search will commence for a permanent director upon grant award. The project director and the administration assistant will be hired simultaneously. Recruitment for all other state staff, including contracted personnel, will begin immediately, although final hiring decisions will be made in consultation with the permanent project director, once he or she has been hired.

Exhibit 14 below presents the detailed staffing timeline.

Exhibit 14 – Vermont MFP Staffing Timeline

Title	Sourcing Option	RFP or Candidate Interviews	Candidate/ Contractor Begins
1 Project Director	Hire	3/1/11	4/15/11
0.5 Administrative Assistant	Hire	3/1/11	4/15/11
3 Transition Coordinators	Hire	3/1/11	5/31/11
2 Community Development Specialists	Contracted	3/1/11	5/31/11
Transition Consultants	Contracted	3/1/11	5/31/11
1 MFP Data Analyst	Hire	3/1/11	5/31/11
2 QM Specialists	Hire	3/1/11	5/31/11

h. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.

DAIL will be the lead entity for the MFP demonstration within AHS and will be responsible for the assessment of performance of the staff involved in the demonstration.

Billing and Reimbursement Procedures. Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

Billing and reimbursement will be managed through the systems currently used for Vermont's waiver services. DAIL has extensive fraud control and financial monitoring systems in place. The Vermont Medicaid Fiscal Intermediary, in concert with the Economic Services Division (ESD) claims payment system, is programmed to deny duplicate claims for waiver services that will be utilized under MFP.

DAIL and the state's fiscal agent (Hewlett Packard) monitor for fraudulent claims billings through these tracking systems and through consumer complaints. Provider manuals address the requirements for provider documentation. There is no anticipation of change to the current system other than those specified by the demonstration grant for reporting purposes.

Prior to claims processing, the automated claims management system edits claims for validity of the information and compliance with business rules for the service/program and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current authorized care plan contains sufficient

units to cover amounts claimed, and that an authorized level of care is registered in the claims management system, the claim will be rejected.

Current procedures provide for fiscal review to examine the provider agency's service delivery and financial records, and to verify that all payments are made to the provider agency were supported and documented. The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, all improper payments can be recovered. The state also recovers payments when it verifies the provider was overpaid because of improper billing. The state may take adverse action against the provider or require a corrective action plan for any fiscal review findings.

D. EVALUATION

Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP demonstration. If these activities are undertaken by the State, the following information must be provided to CMS:

*1. **Evaluator:** If an evaluator has been identified, name the evaluator and provide a resume of the principle investigator in an indexed appendix. Provide a description of the process that will be used to secure an evaluator if one has not yet been identified. Also provide a description of how the State will assure that the evaluator will possess the necessary expertise to conduct a high quality evaluation. Provide a brief description of the organizational and structural administration that will be in place to implement, monitor and operate the evaluation.*

*2. **Evaluation Design:** Provide a description of the State's evaluation design. The description should include the following:*

- a. A discussion of the demonstration hypotheses that will be tested;*
- b. The outcome measures that will be included to evaluate the impact of the demonstration;*
- c. The data source that will be utilized;*
- d. An analysis of the methods used for data collection;*
- e. The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration;*
- f. The method that will be utilized to isolate the effects of the demonstration from other state initiatives and state characteristics (e.g. per capita income and/or population);*
- g. Any other information pertinent to the State's evaluative or formative research via the demonstration operations; and*
- h. Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)*

*3. **Variables:** Describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the application. Describe the instruments and provide a rationale for their use in the evaluation including reliability, validity and appropriateness for use on the study population.*

*4. **Process Evaluation:** Please describe how process measures will be evaluated. Include a description of how infrastructure changes will be evaluated as well as any pilot programs.*

Vermont contracts with the University of Massachusetts to conduct the independent evaluation of the Choices for Care waiver. The state may ask the University to undertake evaluation activities related to the MFP demonstration sometime in the future. However, the state at this

time is not proposing to conduct an independent evaluation of the demonstration. Vermont will fully support the national evaluator in accordance with grant requirements.

E. BUDGET

1. Administrative Budget Presentation: (An electronic submittal form will be provided by CMS)

Please address the following items:

- a. Personnel
- b. Fringe benefits.
- c. Contractual costs, including consultant contracts.
- d. Indirect Charges, by federal regulation.
- e. Travel
- f. Supplies
- g. Equipment
- h. Other costs

Exhibit 15 below presents Vermont's proposed administrative budget, by expense category, for each calendar year of the demonstration.

Exhibit 15 – Vermont MFP Administrative Budget

Category	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Personnel	\$260,590	\$347,454	\$360,131	\$371,852	\$384,384	\$ 99,363
Fringe Benefits	\$114,008	\$152,011	\$157,557	\$162,685	\$168,168	\$ 43,471
Contractual	\$290,000	\$298,400	\$307,052	\$315,964	\$325,142	\$334,597
Travel	\$ 25,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000
Supplies	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000
Equipment	\$20,000	---	---	---	---	---
Other costs	\$ 84,000	\$ 55,000	\$ 55,000	\$ 55,000	\$ 55,000	\$ 55,000
<i>Sub-Total</i>	<i>\$800,598</i>	<i>\$884,865</i>	<i>\$911,741</i>	<i>\$937,501</i>	<i>\$964,694</i>	<i>\$564,431</i>
Indirect Charges*	\$40,030	\$44,243	\$45,587	\$46,875	\$48,235	\$28,222
TOTAL	\$840,628	\$929,108	\$957,328	\$984,376	\$1,012,929	\$592,653

*Indirect charges set at 5 percent of expenditures

2. Administrative Budget: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Please indicate any administrative fund request to be reimbursed fully through the grant. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

The following section provides detailed information for Vermont's proposed administrative expenditures for the five years of the demonstration.

a. Personnel

- **Project Director** – The Project Director is responsible for leading the design, development, implementation and plans for sustaining the CMS MFP demonstration. The Director also will oversee all training activities. DAIL assures that the Project Director will be a 100 percent CMS funded full-time position and CMS will have input into the approval of the person hired.
 - The total cost for CY 2011 is \$49,483.
 - The total cost over the life of the demonstration is \$315,009 (this figure includes an annual inflation rate of three percent).

- **Administrative Assistant** – One half-time clerical position will be dedicated 100 percent to the demonstration and will support the Project Director and workgroups. Vermont is requesting this position be fully reimbursed through the MFP demonstration grant.
 - The total cost for CY 2011 is \$17,670.
 - The total cost over the life of the demonstration is \$112,266 (this figure includes an annual inflation rate of three percent).

- **Transition Coordinators** – Three full-time Transition Coordinators will be hired and located in the north, middle and southern regions of the state. Transition Coordinators will have RN or MSW credentials and will have the following roles/responsibilities: respond to nursing facility referrals; provide referral and support functions; perform transition planning and transition assessments in nursing facilities; communicate potential enrollee information to Choices for Care case managers and work with Choices for Care case managers to develop a care plan and to identify and coordinate specialized supports; work with community development specialists to arrange housing options; provide transition follow-up as necessary to support the participant and case manager; and assist with training activities. Vermont is requesting these positions be fully reimbursed through the MFP demonstration grant since they will be 100 percent dedicated to the grant and play a major role in achieving increases in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program and who receive a transition packet each year, as well as assisting with the safe transition of residents back into the community.
 - The total cost for CY 2011 is \$140,150.
 - The total cost over the life of the demonstration is \$890,726 (this figure includes an annual inflation rate of three percent).

- **MFP Data Analyst** - One full-time Data Analyst position will be dedicated 100 percent to the demonstration and will be responsible for the following: receive and collate documentation for clinical review and approval; perform data analysis and complete

required MFP reports; develop and update the MFP portion of DAIL's website; and assist quality staff to manage program tracking systems. Vermont is requesting this position be fully reimbursed through the MFP demonstration grant.

- The total cost for CY 2011 is \$46,717.
 - The total cost over the life of the demonstration is \$296,909 (this figure includes an annual inflation rate of three percent).

- **Quality Management Specialists** – Two Quality Management Specialists will be hired to perform the following functions: oversee 24/7 back-up system, critical incident and reporting system, and risk mitigation programs; perform all required QM and utilization review activities; assist with independent evaluation as necessary; assist in writing the operational protocol and analyzing data related to the demonstration; manage all requirements related to internal, state and federal reporting, tracking, and data management, including management of MFP benchmarks; oversee certification and licensure reviews of clinical staff and housing; interface with CMS and DAIL on integrity of required data systems; and grant financial and performance reporting. The positions will be dedicated 100 percent to the demonstration and will assist the state in achieving the annual benchmarks by collecting and analyzing data for each of the five benchmarks as well as providing ongoing monitoring of all MFP program activities.
 - The total cost for CY 2011 is \$93,434.
 - The total cost over the life of the demonstration is \$593,817 (this figure includes an annual inflation rate of three percent).

b. Fringe benefits

The fringe benefit rates for each year are 43.75 percent and are included in Exhibit 14.

c. Contractual costs, including consultant contracts

- **Transition Consultants** – Vermont will contract with organizations that do not act as direct service providers to serve as consultants to Transition Coordinators and will perform similar functions. These will likely include a combination of the Vermont Center for Independent Living, Area Agencies on Aging, Designated Agencies, State Independent Living Council, HomeShare Vermont and other local organizations familiar with Vermont’s supportive home- and community-based services. Vermont is requesting these consultants be fully reimbursed through the MFP demonstration grant since they will be 100 percent dedicated to the grant and play a major role in achieving increases in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program and who receive a transition packet each year, as well as assisting with the safe transition of residents back into the community.
 - The total cost for CY 2011 is \$200,000.
 - The total cost over the life of the demonstration is \$1,293,682 (this figure includes an annual inflation rate of three percent).

- **Community Development Specialists** – Two Community Development Specialists will be contracted to perform the following functions: identify the qualified residences for MFP participants; develop strategies for increasing available affordable and accessible

housing; participate in housing workgroups and forums; develop and perform community outreach and marketing across the state; develop a comprehensive list of transportation and other supportive assistance options; perform referral support functions; and assist with training activities. The positions will be dedicated 100 percent to the demonstration and will assist the state in achieving the annual benchmarks of increasing in the number of participants that secure community housing and to meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence.

- The total cost for CY 2011 is \$80,000.
 - The total cost over the life of the demonstration is \$517,473 (this figure includes an annual inflation rate of three percent).

- **Vermont 211** – The state will contract with Vermont 211 services to provide 24/7 toll-free backup services to MFP participants. Therefore, 100 percent federal funding is requested for this contracted service.
 - The total cost for CY 2011 is \$5,000.
 - The total cost over the life of the demonstration is \$30,000.

- **Interpreters Referral Services** – Vermont will contract with an interpreter service to provide telephone translation at no cost. The service will be free to MFP participants. Therefore, 100 percent federal funding is requested for this contracted service.
 - The total cost for CY 2011 is \$5,000.

- The total cost over the life of the demonstration is \$30,000.

d. Indirect charges, by federal regulation

Vermont is applying an indirect charge rate of five percent.

e. Travel

Travel costs cover field-based activities for Transition Coordinators, travel to local, state and regional MFP-related meetings, outreach forums, training sessions, and data collection.

Therefore, 100 percent federal funding is requested for grant-related travel. The total travel cost for CY 2011 is \$25,000. The total cost over the life of the demonstration is \$150,000.

f. Supplies

Costs for supplies built in for each year include paper, printing, telephone, postage and other miscellaneous supplies related to the MFP demonstration. Therefore, 100 percent federal funding is requested for MFP-related supplies. The total supply cost for CY 2011 is \$7,000. The total cost over the life of the demonstration is \$42,000.

g. Equipment

The cost for one new computer per employee is built in budget Year 1. Vermont will also invest in a critical incident database reporting system in Year 1. One hundred percent (100 percent) federal funding is requested for this equipment since it will be used solely for the MFP program. The total equipment cost for CY 2011 is \$20,000.

h. Other Costs

Other costs include training, marketing and outreach materials, rental space for training and outreach forums, translation, broadcasting, and MFP website hosting and development fees. Since the expenses are directly for the MFP program, Vermont is requesting 100 percent federal funding for “other” cost items. The total cost for “other costs” for CY 2011 is \$84,000. The total cost over the life of the demonstration is \$359,000.

Per Capita Costs

The average per participant for service costs associated with this demonstration is \$3,212. The average per participant for administrative costs associated with this demonstration is \$14,179.

3. Evaluation Budget: Please include annual estimated costs of the evaluation activities the State is proposing.

Vermont contracts with the University of Massachusetts to conduct the independent evaluation of the Choices for Care waiver. The state may ask the University to undertake evaluation activities related to the MFP demonstration sometime in the future. However, the state at this time is not proposing to conduct an independent evaluation of the demonstration. Vermont will fully support the national evaluator in accordance with grant requirements.

Please refer to Appendix J for the Required Maintenance of Effort Forms and to Appendix K for the Required Sub Appendix IV - Worksheet for Proposed Budget Form.