

**The Vermont
Money Follows the Person Rebalancing Demonstration
Operational Protocol**



Submitted by:

State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living

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Operational Protocol Abstract

The Money Follows the Person Operational Protocol is documentation that includes the required elements that must be submitted and approved by the Centers for Medicare and Medicaid Services (CMS) in order to enroll individuals into the demonstration or claim Federal dollars for provision of direct services for its participants/members.

The purpose of the Operational Protocol is to provide information for:

- Federal officials and others, so they can understand the operations of the demonstration.
- State and federal monitoring staff planning a visit.
- State Project Directors and staff who use it as a guide to program implementation.
- Regional partners who use it as an operational guide.
- External stakeholders who use it to understand the operation of the demonstration.

Subsequent changes to the MFP Demonstration and the Operational Protocol must be reviewed by the Project Director, Vermont Department of Aging, Disabilities and Independent Living (DAIL), stakeholders and be approved by DAIL and CMS. A request for change must be submitted to CMS 60 days prior to the date of implementing the proposed changes. All aspects of the MFP Demonstration, including any changes to this document, are managed by the Department of Aging and Independent Living.

Project Introduction

The State of Vermont has long demonstrated a commitment to promoting and providing a long-term care system that allows its participants a range of care options appropriate to individual needs and independence by steadily increasing home and community based services. In 2005 DAIL, in collaboration with CMS developed the Choices for Care Section 1115 long-term care waiver program. Since then, Choices for Care has made significant strides in expanding options for long term-care Medicaid beneficiaries. On April 1, 2011 the State of Vermont was awarded and began implementation and participation in the Money Follows the Person (MFP) Rebalancing Demonstration Program as a component of Choices for Care. The Money Follows the Person Program is operated statewide, with a combined budget of \$17.9 million dollars for the term of the grant.

Vermont's Money Follows the Person Program addresses the long-term care services and support needs of older adults, persons with physical disabilities. The primary goals of the Money Follows the Person Demonstration are to provide Choices for Care participants with transition coordination services and \$2,500 in transition funds to offer equal access to a variety of long-term care options in community based settings. The MFP rebalancing initiatives intend to compliment Choices for Care, and also expand service and placement options for all waiver-eligible persons. The demonstration aims to increase the percentage of home and community base services by helping to alleviate barriers to transition, as a way to rebalance Vermont's long-term service and support systems.

State of Vermont Long-term Services and Supports

Vermont's older adults and persons with physical disabilities populations are served through Choices for Care, which is overseen by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) within the Vermont Agency of Human Services. Since 2005 the Choices for Care 1115 waiver has offered home and community based services for VT Medicaid recipients. Choices for Care assist Vermont elders and adults with physical disabilities to pay for long-term care services in the setting of their choice. Participants are offered three program options: Home and Community Based Supports, Enhanced Residential Care, and nursing facility care. Choices for Care Home and Community Based Supports offer consumers a choice of multiple services while living in a community based setting. Home and Community Based Services are offered to eligible participants who reside in qualified private homes, apartments, or in an Adult Family Care Home.

Services include:

- Case management
- Personal Care
- Adult Day
- Respite
- Companion Hours
- Personal Emergency Response
- Assistive Device and Home Modification

Care Options

The Home and Community Based Supports program offers consumers four distinct care management options which include: agency directed care, consumer directed care, surrogate directed care, and Flexible Choices. Consumer and surrogate directed care are both employer-authority options. Flexible Choices is a budget authority option which is based on assessed needs.

24 Hour Care

Adult Family Care Homes are a 24 hour care home and community based service option for eligible Choices for Care Long-Term Medicaid program participants. Adult Family Care Homes provide person centered supports in the residence of a home care provider to no more than two people unrelated to the home provider. The AFC Home option was implemented in September 2013, and was a collaborative effort between MFP, DAIL and community partners to offer eligible residents another HCBS option.

Options Counseling

Vermont's Aging and Disability Resource Connection (ADRC) initiative provides people of all ages, disabilities, and incomes with the information and support they need to make informed decisions about long term services and supports. ADRC builds on the infrastructure of ten 'core partners': the five Area Agencies on Aging (AAAs), the Vermont Center for Independent Living (VCIL), the Brain Injury Association of Vermont (BIAVT), Vermont 211, the Vermont Family Network (VFN) and Green Mountain Self-Advocates (GMSA). Vermont ADRC partners

provide Options Counseling, based on national core competencies and job duties. Options Counselors refer individuals interested in transitioning to the community from a nursing facility, ICF or hospital to the MFP Program.

Contribution of the Money Follows the Person Demonstration

The State of Vermont Department of Disabilities, Aging and Independent Living has implemented and participates in many key initiatives that aid in rebalancing the State's resources. Money Follows the Person has collaborated with several state and community partners to enhance the transition process and available home and community based services. Money Follows the Person partnered with the ADRC to streamline the options counseling process, identified barriers to transition, and lead the development of the Adult Family Care Home service option. While MFP has played an essential role in identifying gaps and barriers to transition, there are additional programs and supports needed to improve the successful transition of participants.

Money Follows the Person and Choices for Care are currently collaborating with the Vermont Assistive Technology Program and Healthy Homes LLC for MFP participants to utilize assistive technology services and evaluations through the use of MFP transition funds.

Money Follows the Person has identified barriers in the transition process and recognized the need to develop a new laser like approach to transition care coordination and services. MFP and other partnering agencies are currently working together to streamline the transition process and service delivery through collaboration with Agencies and enhanced Case Management Services in addition to the current 48 hours. In addition we are working to revamp the Adult Family Care Home model to increase the opportunity for individuals to transition into the community. These services will be covered under Medicaid, and will only be billed during an individual's 12 month transition period as a part of the demonstration projects rebalancing efforts.

Person Centered Planning

Person centered planning is a process directed by the individual or guardian of the individual with long term care needs. It focuses on the individual's strengths, goals, needs and aspirations and puts them in charge of defining the direction of their life. The process includes participants freely chosen by the individual who are able to serve as important contributors. The individual is at the core of all plans and services.

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

setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Money Follows the Person has followed this definition of Person Centered Planning to develop and implement its demonstration services and its policies in working with the individuals that it serves. Keeping in line with the mission of the Division of Disabilities, Aging and Independent Living, Money Follows the Person offers participants choice in the services offered and a voice in the development of new initiatives through stakeholder involvement.

Self-Direction

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 their Choices for Care home-based service plan.

MFP demonstration participants are afforded the same options to self-direct their services as other Choices for Care enrollees. As in the current program, case managers will be responsible for training and assisting individuals to understand the obligations and procedures of self-direction.

Stakeholder Involvement

Vermont involves both private and public stakeholders in oversight and evaluation of the Choices for Care program. The state involves consumers through the Department Aging and Independent Living (DAIL) Advisory Board. 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.

Benchmarks

Vermont's MFP Program annually measures its progress based on five benchmarks, two specifically required by CMS, and three that have been selected by the state. The benchmarks are

used to assess Vermont’s progress in transitioning individuals to the community, and rebalancing its long-term care system.

MFP annually reviews these benchmarks to determine if they are attainable, appropriate and focused on creating lasting improvements and enhancements to the current program.

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.

This population benchmark projects the number of MFP eligible individuals by target population who will be assisted to transition to qualified residences in each calendar year for the term of the grant.

Calendar Year	Older adults	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total
CY 2012	23	-	2	-	-	25
CY 2013	60	-	10	-	-	70
CY 2014	44	-	8	-	-	52
CY 2015	45	-	8	-	-	53
CY 2016	47	-	8	-	-	55
CY 2017	48	-	9	-	-	57
CY2018	37	-	7	-	-	44

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

The MFP rebalancing demonstration offers Vermont an opportunity to increase Medicaid support for Home and Community Based long-term services for each calendar year of the demonstration. The expenditure projections are for all State of Vermont long-term care (not only MFP) HCBS benefits and include both state and federal dollars. Expenditures are increased at an annual rate of two percent, based on historical trends and projected program budget growth.

Year	Expenditures
CY 2012	\$56,890,315
CY 2013	\$58,028,121
CY 2014	\$59,188,684
CY 2015	\$60,372,457

CY 2016	\$61,579,906
CY 2017	\$62,811,505
CY2018	\$64,067,735

Vermont proposes the following three additional success benchmarks to measure performance under the demonstration. As described in detail below, the benchmarks will serve to document the state's progress toward rebalancing Vermont's long term care system through reinvestment of enhanced FMAP savings.

Benchmark 3 – Develop and Implement Adult Family Care Homes

Adult Family Care Homes became an HCBS in September of 2013. MFP was a leading partner in the development and implementation of this new model. The State anticipates that AFC will fill an unmet need in the CFC service continuum and play an important role in program rebalancing. MFP will continue to monitor this new service over the course of the demonstration, and expects to transition 10% of the projected MFP Annual Transitions into Adult Family Care Homes each year.

Year	MFP Transition to AFC Homes
CY 2012	-
CY 2013	-
CY 2014	5
CY 2015	7
CY 2016	9
CY 2017	11
CY2018	13

Benchmark 4 - Increase in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program.

This benchmark measures the number of Medicaid-eligible nursing facility residents who will be informed of the MFP demonstration each year. Transition Coordinators will play an essential role in generating awareness of the demonstration among nursing facility residents and their families, which is a necessary precursor to identifying and assisting demonstration participants.

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

Year	Projected MFP Eligible Residents
CY 2011	100
CY 2012	105
CY 2013	110
CY 2014	115
CY 2015	120
CY 2016	125
CY 2017	130
CY 2018	135

Benchmark 5 – Percentage of MFP participants will remain in the community for at least 1 year after transition.

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 365 days. The state has set a benchmark of 80 percent of transitions in 2012 to remain in the community for at least one year after transition. By consistently reaching this milestone, the state will maximize the enhanced FMAP available for reinvestment toward further program rebalancing.

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

Year	Total Transitioning Residents	Number Remaining in HCBS 1 CY after Transition
CY 2012	25	20
CY 2013	70	56
CY 2014	52	42
CY 2015	53	42
CY 2016	55	44
CY 2017	57	46
CY 2018	44	35

Demonstration Policies and Procedures

Education and Marketing

The target populations for the Money Follows the Person Demonstration are Medicaid eligible Vermont residents currently residing in Medicaid participating nursing facilities, hospitals and Intermediate Care Facilities. There are approximately 1700 Medicaid eligible residents in these facilities across the state.

Money Follows the Person educated 1331 Medicaid eligible Nursing Facility Residents in 2012 and 2013. Money Follows the Person has developed targeted educational systems to identify and assist demonstration participants.

MFP Recruiting Tools

Persons interested in the Money Follows the Person Demonstration can receive information about the program through the following mechanisms:

- Marketing literature; available upon request in alternative formats. APPENDIX A
- MFP website: <http://www.ddas.vermont.gov/ddas-projects/mfp/mfp-default>
- Vermont's 211 hotline
- Community outreach and presentations
- Videos
- Consumer success stories

Targeted Education

The MFP Data Analyst generates 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 in a qualified facility. The report is provided to the Transition Coordinators, who will make monthly visits to all nursing facilities in their regions. Residents receive a brochure and are educated about the MFP Program. Their response is recorded by the Transition Coordinator in the SAMs database and the Transition Coordinators follow-up on the information and consults with facility discharge planners.

MDS 3.0 Section Q

The Aging and Disability Resource Connection is comprised of the Vermont Center for Independent Living (VCIL) the Area Agencies on Aging, and the Home Health Agencies. The ADRC plays an important role in supporting care transitions, and serves as the Local Area Contact Agencies for the MDS 3.0 Section Q discharge process.

The Vermont ADRC/MFP and Section Q Implementation Strategy process is 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 (Process found in APPENDIX B and referral form in APPENDIX C) for the Local Contact Agency. The LCA will then conduct

options counseling and determine if an individual may be eligible for MFP and generate a referral to MFP.

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.

Eligibility and Enrollment - See policy APPENDIX D

Individuals who meet the criteria below are eligible to enroll in the Money Follows the Person (MFP) Demonstration Project.

- Vermont resident.
- Meet requirements for 90 consecutive days in a qualified inpatient facility, excluding nursing facility Medicare-rehabilitation days.
- Receiving Vermont Long-Term Care Medicaid for at least one day prior to transition from the qualifying inpatient stay.
- Express a desire to live in a community setting.

Eligibility is verified at time of enrollment and at transition by the Transition Coordinator and quarterly by the Data Analyst.

Informed Consent

All participants (or as appropriate, family members or guardians) will be required to sign an informed 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.

A Transition Coordinator will thoroughly review the Money Follows the Person Brochure 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. The MFP Consent Form is located in APPENDIX E

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.

A candidate/facility resident is assumed to be competent and able to consent to participation in the MFP Demonstration, unless the candidate/facility resident has been deemed incapacitated by a court and a legal guardian has been appointed. If the candidate/facility resident does not have a court-appointed guardian he/she has the right to make decisions regarding their participation.

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 habilitating 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.

To become a participant the individual must be enrolled and Transition into a Qualified Residence.

Qualified Residence

To participate in MFP the person must transition to a qualified MFP residence on the date of transition. See APPENDIX D

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), Licensed Level III Residential Care (including enhanced residential care), and Assisted Living Residences. These three 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 Transition Coordinators and case managers. They will not be formally licensed by DAIL's Division of Licensing and Protection.

Participation in Money Follows the Person

The person's MFP participation will continue through the first 365 days post-transition. Any days spent in an inpatient setting do not count towards the 365 MFP post-transition participation days. Please see APPENDIX D for policy regarding participation suspension, de-enrollment, and re-enrollments.

Retro-Active Participation

Money Follows the Person's education and referral systems aim to reach all Choices for Care Participants that are eligible for Money Follows the Person. When Money Follows the Person does not reach the Choices for Care Participant prior to discharge to HCBS, the person may choose to become a Retroactive Participant in the Money Follows the Person demonstration. Retroactive enrollment and participation begin on the day the individual transitioned from the qualifying inpatient setting to the qualified MFP home and community based residence. See APPENDIX D.

Benefits and Services

Money Follows the Person Participants must be enrolled in the State's Section 1115 Choices for Care Waiver. In addition to the services received through the 1115 waiver's fee for service model, Money Follows the Person participants may receive additional benefits and services through the demonstration.

Service Options	Qualified HCBS	HCBS Demonstration
Personal Care Services (including homemaker tasks)	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	X	
Case Management Services	X	
Other living arrangements	X	
One-time transition payment		X
Case Management	X	

Transition Funds

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. Vermont offers a one-time transition assistance payment of \$2,500 as a demonstration service. MFP enrollees are eligible to receive Transition Funds to help remove identified barriers to transitioning and remaining on Home and Community Based Services. The funds can be accessed from the date of MFP enrollment through 90 days after transition to a qualified home and community based setting.

Retroactive participants are eligible for financial assistance, up to \$2500, for items or services intended to help the Retroactive participant successfully remain in a home and community based setting. Approved MFP funds can be accessed for 90 days from the date the MFP Informed Consent is signed or until the participant reaches 365 days of participation, whichever is sooner.

Expenses must be deemed modest and reasonable and must be pre-approved by MFP. MFP Transition Funds will not pay for past-due expenses. APPENDIX D identifies the policy for the use of Transition Funds, APPENDIX F is the Transition Funds Process and Request Form and APPENDIX G describes the Transition Funds billing policy and procedures.

Consumer Supports

Money Follows the Person demonstration participants utilize 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, both during the MFP demonstration and thereafter.

Provider Network

Providers in Vermont's MFP demonstration include medical directors, administrators, discharge planners and social workers employed in nursing facilities as well as the array of home and community based service providers.

- **Home Health Agencies:** Provides a wide range of high-quality care for people of all ages, with acute and long term illnesses. In addition to skilled nursing services, specialty nurses coordinate high-quality individualized care. Licensed Nursing Assistants assist with personal care and activities of daily living.
- **Area Agencies on Aging:** These agencies coordinate and support a wide range of home- and community-based services, including information and referral, home-delivered and congregate meals, transportation, employment services, senior centers, adult day care and a long-term care ombudsman program. They also provide assistance for adults in need of protection or supportive services.
- **Vermont Center for Independent Living:** The Vermont Center for Independent Living (VCIL) is a non-profit organization directed and staffed by individuals with disabilities, works to promote the dignity, independence and civil rights of Vermonters with

disabilities. Like other independent living centers across the country, VCIL is committed to cross-disability services, the promotion of active citizenship and working with others to create services that support self-determination and full participation in community life.

- **Authorized Agencies:** Agencies Authorized by DAIL to provide Adult Family Care to eligible participants. This includes oversight and management of AFC services and payment to AFC Homes.
- **Adult Day Providers:** Adult Day Centers provide an array of services to help older adults and adults with disabilities to remain as independent as possible in their own homes. Adult day services provide programs during the daytime. Programs include activities, social interaction, nutritious meals, health screening and monitoring, personal care, and transportation. Respite for family caregivers is also available.

Quality Programs

Vermont has integrated the MFP demonstration into its existing 1115 waiver program to serve individuals during and after the MFP transition year. MFP works with the existing infrastructure to ensure that the MFP demonstration is operated in compliance with federal waiver assurances. DAIL provides additional oversight to assure the demonstration complies with federal assurances and other federal requirements.

Participants in the MFP demonstration are 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.

In addition to the quality oversight that DAIL provides, Money Follows the Person has designed and implemented quality systems to oversee the specific needs of the demonstration. These systems include developing policies, procedures and reporting systems for Demonstration Services, Quality of Life Surveys and CMS Reporting.

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.

Complaints

MFP Participants have several options for registering complaints about services or any other aspect of their care. MFP participants will be informed about grievance procedures upon enrollment by their Transition Coordinator. 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 DAIL, the participant's case manager, 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 use the online reporting form.

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 own homes or Adult Family Care Homes through Choices for Care.

The Ombudsman Program improves Vermont's long term care system through individual complaint resolution, education, administrative and legislative advocacy. Ombudsmen are available to receive and investigate complaints that consumers or 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.

Critical Incident Reporting

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. Money Follows the Person has developed a reporting policy and procedures for investigation and remediation. APPENDIX H.

Any CFC service provider that becomes aware of a critical incident described in the policy is required to complete a critical incident report form APPENDIX I and submit it to Adult Services Division, as soon as possible, and no later than **48 hours of discovery of the incident**.

DAIL will be the responsible state agency for overseeing the training, reporting of and response to critical incidents for MFP participants. DAIL has developed a Quality Improvement 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

Money Follows the Person has developed a Critical Incident Reporting Database designed to track incidents, monitor technical assistance and dispositions (including requests for additional information regarding incidents and status of Critical Incidents) and conduct tracking, reporting, and analysis of critical incident trends. The Critical Incident Reporting Database has been designed to report data elements that are reviewed by the Quality Improvement Committee to ensure 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.

Financial Accountability

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 payer 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.

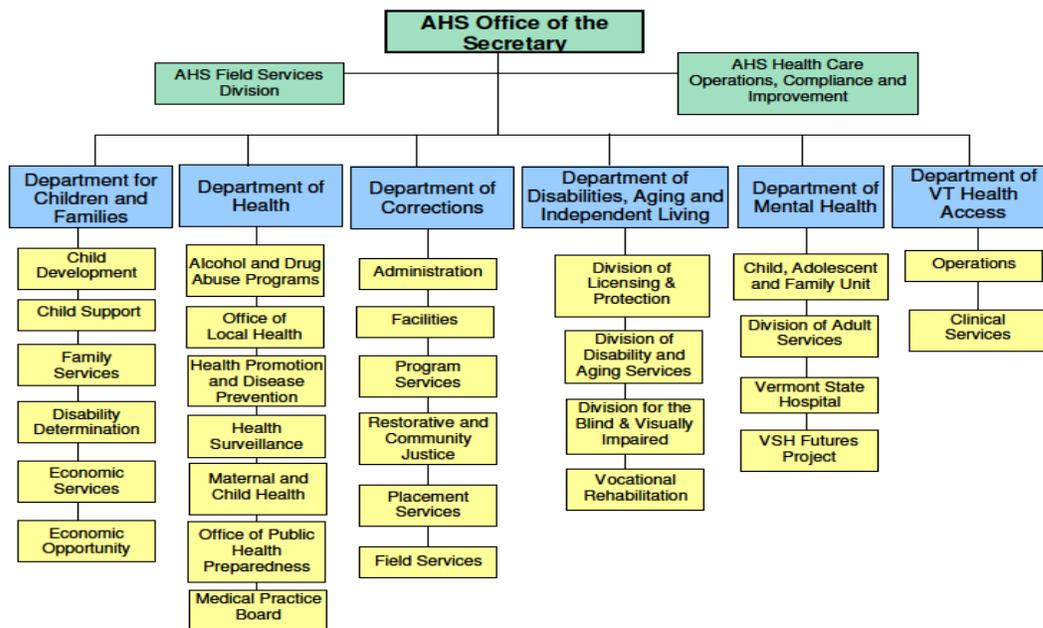
Administration

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

Money Follows the Person is a fully integrated component of Choices for Care. The Department of Disabilities, Aging and Independent Living (DAIL) is the lead agency for the MFP Demonstration and Choices for Care within AHS. DAIL is responsible for the day to day management of the grant and coordinates its activities.

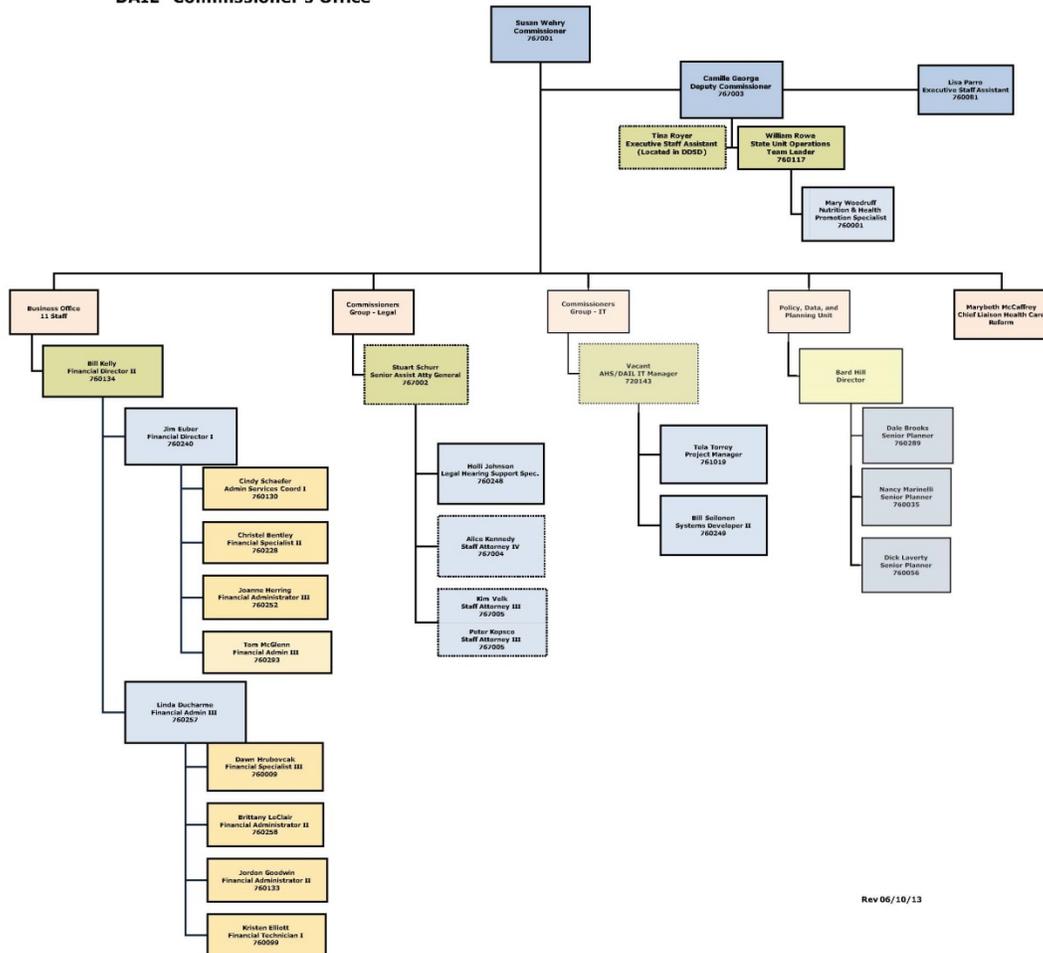
DAIL will coordinate activities between the state’s Medicaid agencies, the Department of Vermont Health Access (DVHA), which is also located within AHS. DAIL and DVHA work closely together on administration and reporting activities for Choices for Care and MFP Demonstration. Other partnering agencies that reside 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 (DMH).

The following diagrams below show the administrative structure for the MFP Demonstration.



Created by C. Young

DAIL -Commissioner's Office



Rev 06/10/13

Staffing

FTE	Title	Role
1	Project Director	
.5	Administrative Assistant	
1	Data Analyst	
1	Quality and Program Specialist	
2	Quality and Program Specialist/Transition Coordinator	
2	Transition Coordinator	

Evaluation

Vermont at this time has not, and is not proposing to conduct an evaluation of the MFP Demonstration. Vermont contracts with the University of Massachusetts to conduct independent evaluations of the Choices for Care Waiver. Vermont will utilize the University of Massachusetts to conduct an evaluation if there is a need in the future. Vermont will fully support the national evaluator in accordance with grant requirements.

Budget

The Budget is submitted annually to CMS using the electronic submittal form provided.

Appendix A



Choices For Care


Money Follows the Person

Your Choice.....Your Voice

Phone: (802)871-3067
Email: ahs.mfp@state.vt.us
<http://ddas.vt.gov/ddas-projects/mfp>



VERMONT
AGENCY OF HUMAN SERVICES
DEPT. OF DISABILITIES, AGING & INDEPENDENT LIVING



VISION

Hear their voice.....support their choice.

MISSION STATEMENT

To maximize autonomy, choice and dignity by providing access to a wide range of high quality long term care options, that allow individuals to live in their chosen community.

What are the Goals of MFP?

- To encourage freedom of choice through person centered planning.
- To eliminate barriers and increase home and community based services to eligible people who choose to transition from an institution to a community setting.



What is Money Follows the Person?

If you have lived in a hospital, or nursing home for at least 90 consecutive days and would rather live in your own home, apartment or group setting you may be eligible for home and community based services (HCBS) through Choices for Care Long-Term Medicaid Program. MFP helps people return to the community of their choice with the supports they need. MFP transition funds provide one-time financial assistance up to \$2,500 to assist with items and services not typically covered by Medicaid.

- Transition Funds cover barriers such as:
- Security Deposits
 - Household items
 - Home Modifications
 - Durable Medical Equipment
 - Appliances
 - Medication Management

Money Follows the Person provides services and supports based on the individual needs of the participant.



Eligibility

Individuals who meet the following criteria are eligible to enroll in Money Follows the Person (MFP) Program benefits.

- Express a desire to live in a community based setting.
- Are a Vermont resident.
- Have been in a qualified inpatient facility, excluding nursing facility Medicare rehabilitation for 90 days or more.
- Are receiving Vermont Long-Term Care Medicaid for at least one day prior to transition from the qualifying in patient stay.

Person Centered Planning



Person centered planning is a process directed by the individual or guardian of the individual with long term care needs. It focuses on the individual's strengths, goals, needs and aspirations and puts them in charge of defining the direction of their life. The process includes participants freely chosen by the individual who are able to serve as important contributors. The individual is at the core of all plans and services.

Home and Community Based Services

MFP participants enter the Choices for Care Medicaid waiver program immediately upon discharge from the nursing facility or institution. Choices for Care Long-term Care Medicaid waiver program provides individuals with long-term care services.

- Personal Care Services (including homemaker tasks)
- Respite Care (temporary break for unpaid care givers)
- Companion and adult day services
- Personal Emergency Response Systems
- Assistive devices and home modifications

Where can I Live?



To participate in MFP you must transition into one of the following qualified housing options:

- A Home Owned or Leased
- An Apartment
- Community Based Residential Setting
- Adult Family Care Home - A housing option that provides continuous individualized supports in a family oriented environment.

Who Will Help Me?

Your transition team is made up of friends, family members, providers and anyone who contributes to your physical, mental, and emotional well-being. The Team will include your MFP Transition Coordinator and Waiver Case Manager, your family and friends and others you choose for assistance and support.



MFP Transition Coordinators

provide case management services to help guide your transition back into the community. They will help you identify and overcome barriers and work with your health care team to get you the resources you need to be successful and remain in the community of your choice.



For more information and to get started on your way home:

Phone: (802) 871-3067

E-mail: ahs.mfp@state.vt.us

Website: <http://ddas.vt.gov/ddas-projects/mfp>

Additional Assistance



Vermont's Center for Independent Living
I-Line offers specialized assistance to help you achieve your independence.
1-800-639-1522



VT Area Agencies on Aging
1-800-642-5119

Vermont Area Agencies on Aging Senior Help Line
provides information and assistance to Vermont seniors and their families.



Dial 2-1-1 for health and human services information.

This document was developed under CFDA 83.791 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Money Follows the Person is a demonstration grant funded by CMS in partnership with the State of Vermont Agency of Human Services. However, the contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement from the federal government.

**ALL 85 Division of Disability and Aging Services
Money Follows the Person, 103 S. Main St. Weeks Bldg.,
Waterbury, VT 05671**

For more information:

Phone: 802-871-3067

E-mail: ahs.mfp@state.vt.us

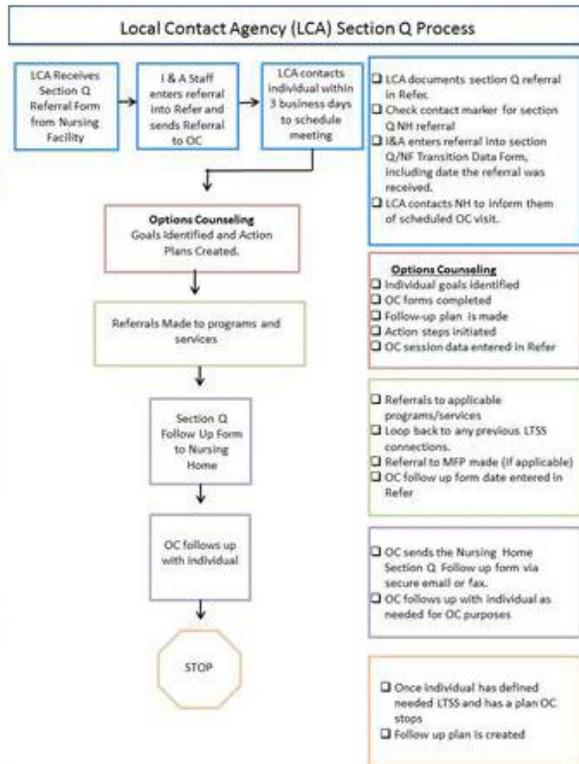
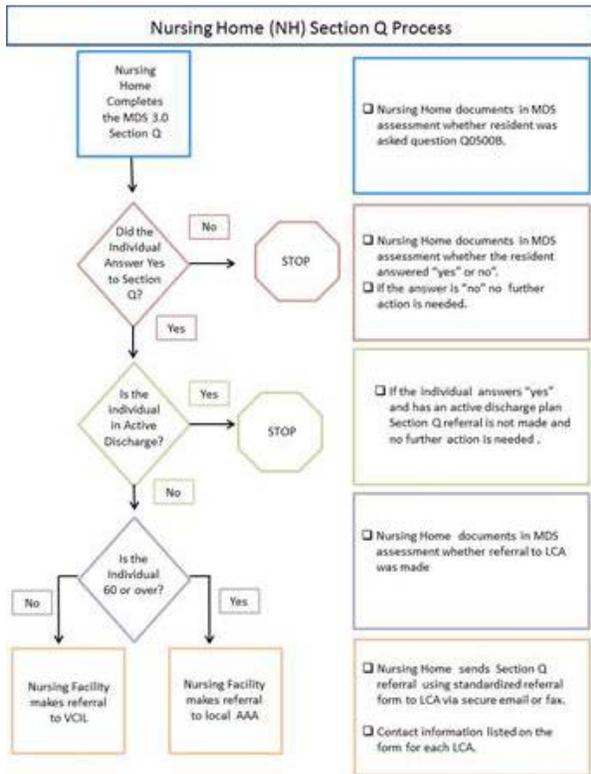
Website:

<http://ddas.vt.gov/ddas-projects/mfp>

Choices For Care



Alternative formats and translations available upon request



Appendix C

Vermont Department of Disabilities, Aging and Independent Living



Section Q and Nursing Home Transition Referral Form: Final October 2013

Instructions: Please complete this form for **ALL INDIVIDUALS** who answer "yes" to the MDS 3.0 Question Q0500B and for all individuals who express a desire to transition out of a nursing home, **regardless of whether this request was part of the MDS 3.0 assessment**. Such a request may be made outside of a formal MDS assessment and should be referred to the Local Contact Agency for Options Counseling.

All referrals must be e-mailed via SECURE email or if not secure, via fax, to the contact e-mail and fax numbers listed below. For individuals age 60 and over, please refer to your local Area Agency on Aging by selecting from the list below. For individuals under age 60, please refer to the Vermont Center for Independent Living from the list below.

Area Agency on Aging for age 60 and over:

Vermont Center for Independent Living for under age 60:

Consumer Referral Information (All fields are required.)

Date of Referral: Nursing Home Making Referral: Please select from the list below.

First Name of Staff Making Referral:

Last Name of Staff Making Referral:

Email Address of Staff Making Referral:

Phone Number of Staff Making Referral:

Fax Number for Staff Making Referral:

Other Referral Source if not the Nursing Home: Please select from the list below.

Individual's/Resident's First Name:

Individual's/Resident's Last Name:

Individual's/Resident's Date of Birth:

Individual's/Resident's Town of Residence: Please select from the list below.

Medicaid Number: Please insert 14-digit number below.

Nursing Home Date of Admission:

Appendix D

Money Follows the Person Eligibility and Enrollment Guidelines

Eligibility Criteria

Individual's who meet the criteria below are eligible to enroll in the Money Follows the Person (MFP) Demonstration Project.

Vermont resident.

Meet requirements for 90 consecutive days in a qualified inpatient facility, excluding nursing facility Medicare-rehabilitation days.

Receiving Vermont Long-Term Care Medicaid for at least one day prior to transition from the qualifying inpatient stay.

Express a desire to live in a community setting.

Qualified Inpatient Facility

A qualified inpatient facility includes the following institutions.

Nursing facility

Hospital

The qualified inpatient stay must be immediately before beginning participation in the MFP demonstration project.

Nursing Facility Medicare Rehabilitation Exclusion

When a person is admitted to a skilled nursing facility solely for the purposes of skilled rehabilitation services covered under Medicare hospital insurance Part A, up to 100 of these days are not considered toward the 90-day qualified stay.

Enrollment

To enroll in the Money Follows the Person Program an eligible individual must sign the MFP Informed Consent form and an Application Referral form.

Participation

To become a participant the individual must be enrolled and Transition into a Qualified Residence.

Qualified Residence

To participate in MFP the person must transition to a qualified MFP residence on the date of transition.

5. 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.
6. 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.
7. 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), Licensed Level III Residential Care (including enhanced residential care), and Assisted Living Residences. These three types of community based alternative residential settings are regulated by DAIL, Division of Licensing and Protection.
8. 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.

Period of Participation

The person's MFP participation will continue through the first 365 days post-transition. Any days spent in an inpatient setting do not count towards the 365 MFP post-transition participation days.

Temporary Suspension of Participation

If an MFP participant spends 30 days or fewer in an inpatient setting for any reason during a person's participation period, the person remains a participant in MFP.

If an inpatient stay occurs within 90 days of leaving the qualifying inpatient stay, MFP will extend the date for accessing the unused MFP Transition Funds by the number of days spent in an inpatient setting.

Suspension of Participation

If an MFP participant spends 31 days or more in an inpatient setting the individual's MFP participation is suspended. The individual may continue to be enrolled in the MFP program.

After 90 continuous days in the inpatient facility the individual's enrollment in MFP will end.

Re-Activation of MFP Participation Status

If an individual is deemed eligible for MFP after an inpatient stay of more than 31 days and less than 90 days the individual may be re-activated as a participant without re-establishing the 90-day inpatient requirement.

Prior to transitioning back to home and community based services a thorough review of the previous transition's care plan will be conducted to mitigate any obstacles for another transition.

If an inpatient stay occurs within 90 days of leaving the qualifying inpatient stay, MFP will extend the date for accessing the unused MFP Transition Funds by the number of days spent in an inpatient setting.

When re-activated into MFP, the participant continues their initial MFP enrollment through the 365 days of participation (excluding days in an inpatient setting).

The participant can have two re-activations of participation within an enrollment.

Re-Enrollment

An individual can be enrolled in the MFP program three times.

Prior to transitioning back to home and community based services a thorough review of the previous transition's care plan will be conducted to mitigate any obstacles for another transition.

Retroactive Eligibility

People receiving Vermont Long-Term Care Medicaid Choices for Care Home and Community Based Services are retroactively eligible to enroll in MFP when they meet MFP Eligibility as of 4/1/2011.

Effective Enrollment

The effective enrollment is the date the individual signs the Informed Consent form and the Application Referral form.

Retroactive Enrollment and Participation

Retroactive enrollment and participation begin on the day the individual transitioned from the qualifying inpatient setting to the qualified MFP home and community based residence.

Retroactive Participation Guidance

The guidance for participation period, participant's temporary suspension, suspension, re-admittance, and re-enrollment apply to retroactive participants.

Note: If the participation period is completed before the effective enrollment, the retroactive enrollment will not count as one of the three enrollments available to the participant. Transition Funds are not available for individuals whose participation period has ended.

Transition Funds

MFP enrollees are eligible for financial assistance, up to \$2500, to help remove identified barriers to transitioning and remaining on Home and Community Based Services. The funds can be accessed from the date of MFP enrollment through 90 days after transition to a qualified home and community based setting.

Retroactive participants are eligible for financial assistance, up to \$2500, for items or services intended to help the Retroactive participant successfully remain in a home and community based setting. Approved MFP funds can be accessed for 90 days from the date the MFP Informed Consent is signed or until the participant reaches 365 days of participation, whichever is sooner.

Expenses must be deemed modest and reasonable and must be pre-approved by MFP. MFP Transition Funds will not pay for past-due expenses.

Appendix E



Choices For Care

Personalize your care options

Money Follows the Person Demonstration Project

Informed Consent

I, _____, freely choose to participate in the Vermont Money Follows the Person (MFP) program. I understand that this program allows me to receive a limited amount of flexible funds for expenses related to my transition from the nursing facility where I currently live to a new home in the community.

I have received information about the MFP program and am aware of all aspects of the transition process. I have also received information about the services and supports that will be provided to me both during the MFP demonstration and thereafter, which are all part of the Choices For Care Program.

I understand that participation in MFP is voluntary and that I can withdraw from participation in the MFP project at any time. I understand that I will participate in developing a plan of care that outlines my services, a backup plan and my emergency contact list.

I understand that agreeing to participate in the MFP program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my MFP program eligibility. I understand that there are no additional risks anticipated based on my participation in the MFP program beyond the risks related to receiving services in a community setting, for which I have already provided my consent. I have also been provided with a copy of the Choices For Care Participant Handbook that outlines my rights and responsibilities.

In order to participate in the MFP program, I have been informed that I must meet all of the eligibility requirements specific to the MFP program, which include residing in an inpatient facility for at least ninety (90) consecutive days; receiving Medicaid benefits for inpatient services; and that I must choose to live in a qualified residence, defined as:

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), Licensed Level III Residential Care (including enhanced residential care), and Assisted Living Residences. These three types of community based alternative residential settings are regulated by DAIL, Division of Licensing and Protection.

Appendix F

Money Follows the Person Transition Funds Request Form

Section 1 - For Case Manager only:

Fax Completed form to: (802) 871-3052

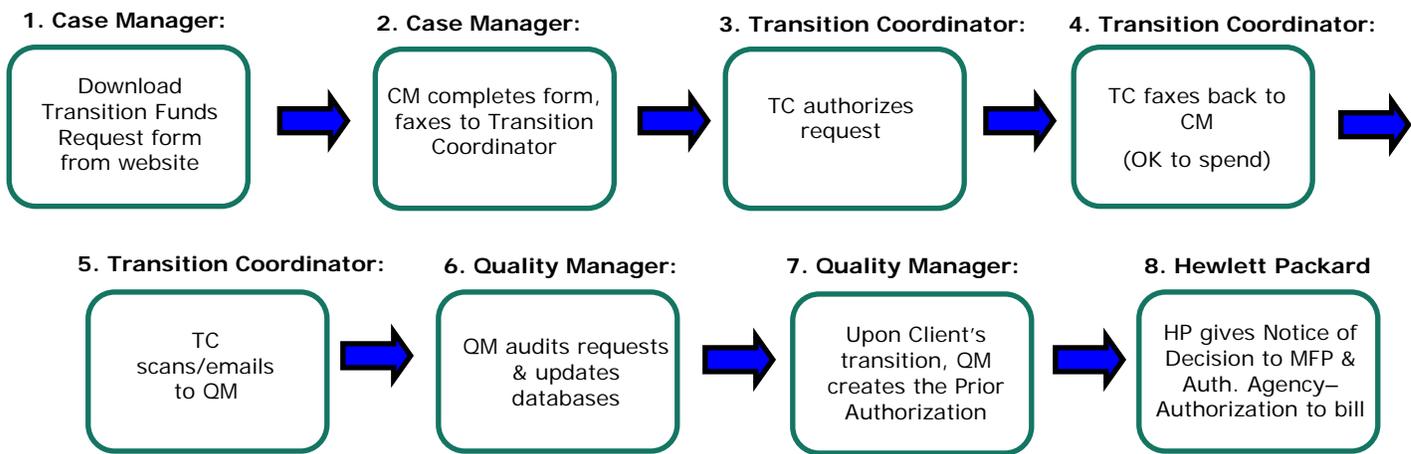
1. Participant's Name:		
2. Participant's Social Security Number:		
3. Date of Birth:		
Item Requested	\$ COST	Comments
Subtotal:		
Total Prior:		
Total Cost this request + cost of all prior requests: (Total cost must not exceed \$2,500 per enrollment)	\$	
5. Agency Name:	Phone:	
6. VT Medicaid Provider Billing Number:		
7. Case Manager's Name:	Phone:	Fax:
8. Case Manager's E-mail:		
9. Case Manager's Signature:	Date:	

Section 2 - For Transition Coordinators only:

The TC signature authorizes the agency to spend the above request. Authorization for the billing of these claims will occur according to the instructions on the back of this page.

MFP TC Signature:	Date:
-------------------	-------

MFP Transition Funds Request Form Process:



MFP Transition Funds Request Form Policies:

Money Follows the Person Transition Funds Approval Policy:

By signing this form, the Case Manager assures the assistive devices, home modifications or other barriers are not otherwise available to the individual through Medicare, Medicaid, or private insurance coverage. Additionally, the Case Manager assures applicable Choices for Care standards and procedures have been followed in developing this

request. For complete Billing Procedure, please go to:

<http://ddas.vt.gov/ddas-projects/mfp/policiesprocedures/billing/billing-procedure>

Money Follows the Person Transition Funds Billing Policy - Billing Policy FAQs:

Q: When can I submit a claim?

A: After the identified recipient discharges from a nursing facility into an MFP Qualified Home and Community Based setting, MFP Transition Funds service providers shall submit claims for pre- approved MFP transition expenditures using revenue code 087, MFP Transition Funds. Providers billing electronically via Provider Electronic Solutions (PES) must add an extra zero to the revenue code (0087).

Q: When can Transition Funds be spent?

A: ALL FUNDS MUST BE SPENT WITHIN 90 DAYS OF TRANSITION OUT OF NURSING FACILITY

Q: Can I submit 087 Rev. Code claims with other & home community-based services?

A: Claims submitted for MFP Transition Funds services shall bill only revenue code 087. Providers billing revenue

code 087 in addition to other codes on a single Medicaid claim shall be required to re-bill MFP Transition Funds services separately.

Q: In the event that an MFP enrollee decides not to discharge, what do I do?

A: In the event an MFP enrollee does not discharge as expected from the institutional setting or does not transition into qualified MFP housing, MFP will issue a Medicaid PA to the provider authorizing billing of MFP funds spent to date, on behalf of the recipient.

Appendix G

Money Follows the Person Provider Enrollment & Transition Funds Billing Procedures

A. Provider Enrollment

To provide Money Follows the Person (MFP) Transition Funds services, providers must be currently enrolled as a Choices for Care (CFC) Case Management provider or Transitions II/Statewide Intermediary Service Organization in the Medicaid claims processing system via Hewlett Packard Enterprise Services (HP). CFC provider enrollment requirements are described in Section V.10 of the Vermont Department of Disabilities, Aging and Independent Living Choices for Care, Long-term Care Medicaid Program Manual.

B. Claims

1. MFP Transition Funds service providers shall only submit claims for Medicaid reimbursement for services that have been provided to MFP eligible individuals in compliance with applicable service definitions, provider qualifications, and standards.
2. MFP Transition Funds service providers shall submit claims for Transition Funds services (revenue code 087) through Vermont's Medicaid Management Information System (MMIS), managed by Vermont's Medicaid fiscal intermediary, Hewlett Packard Enterprise Services (HP), in accordance with HP procedures. Questions about claims, payments, and claims procedures should be addressed to HP (802-879-4450).
3. MFP Transition Funds service providers shall have mechanisms or procedures in place to assure that claims which are submitted are accurate and in compliance with all applicable MFP procedures and regulations.
4. An itemized MFP Transition Funds Request Form pre-authorizing MFP Transition Funds expenditures must be approved by the area MFP Transition Coordinator.
5. MFP Transition Funds service providers are responsible for preparing and submitting claims for pre-approved MFP Transition Funds services as well as pre-approved MFP Transition Funds services provided by a variety of organizations and individuals.
6. After the identified recipient discharges from a nursing facility into an MFP Qualified Home and Community Based setting, MFP Transition Funds service providers shall submit claims for pre-approved MFP transition expenditures using revenue code 087, MFP Transition Funds.

Reminder: Providers billing electronically via Provider Electronic Solutions (PES) must add an extra zero to the revenue code (0087).

7. Prior to submitting an MFP Transition Funds claim to Vermont Medicaid, the provider must receive a Medicaid Prior Authorization (PA) Notice of Decision from HP Enterprise Services. The PA will approve reimbursement of up to \$2500 of MFP Transition Funds (revenue code 087) for the recipient for a specified date-range. Although only one \$2500 PA

is issued per recipient per MFP enrollment, each itemized expenditure must be pre-approved per an MFP Transition Funds Request Form. For questions regarding MMIS Prior Authorization status, contact MFP (802-871-3067).

8. In the event an MFP enrollee does not discharge as expected from the institutional setting or does not transition into qualified MFP housing, MFP will issue a Medicaid PA to the provider authorizing billing of MFP funds spent to date on behalf of the recipient.
9. The following dates-of-service are to be used.
 - Items such as assistive devices:
The date-of-service will always be the date the item was received by the individual.
 - Services such as home modifications:
The date-of-service will always be the date the service work was completed.
 - Payments such as a rent deposit:
The date-of-service will always be the date the payment is made to the service.
10. Claims submitted for MFP Transition Funds services shall bill only revenue code 087. Providers billing revenue code 087 in addition to other codes on a single Medicaid claim shall be required to re-bill MFP Transition Funds services separately.
11. Providers shall bill one detail per date-of-service reflecting the total revenue code 087 services per date-of-service.
12. Multiple dates-of-service are accepted on a single claim.
13. MFP Transition Funds service providers must obtain and retain copies of the approved Money Follows the Person Transition Funds Request Form for every MFP enrollee receiving transition services. The approved Money Follows the Person Transition Funds Request Form specifies the service, cost as well as the start date and end date of approval. Only claims for services that comply with the details and limitations of the approved Money Follows the Person Transition Funds Request Form may be submitted to the Medicaid claims processing system.

Appendix H

SECTION V.14. Critical Incident Reporting

Critical Incident (hereafter referred to as incident) reports are essential methods of documenting, evaluating and monitoring certain **serious or severe** occurrences, and ensuring that the necessary people receive the information. These guidelines describe the information that the ASD need to carry out their monitoring and oversight responsibilities. Content reflects standard definitions, applicable populations for required reporting, timelines, and methods for reporting incidents.

A. Definition

Critical Incident is a serious or severe situation in which:

- Any actual or alleged event, incident or course of action involving the perceived or actual threat to a participant's health and welfare; or
- Any actual or alleged event, incident or course of action involving the perceived or actual threat to his/her ability to remain in the community.

B. Choices for Care (CFC) Services Subject to Critical Incident Reporting

As of August 2013, participants utilizing the following CFC services are subject to the Adult Services Division (ASD) Critical Incident process outlined in this section:

- Adult Family Care Home, and
- Money Follows the Person in all CFC settings.

C. Types of incidents that must be reported to Adult Services Division (ASD)

The types of situations that must be reported to ASD include but are not limited to the following incident types.

1. Alleged abuse/neglect & exploitation

All actual or suspected abuse, neglect or exploitation of or by a person enrolled in services as required by 33 V.S.A. Chapter 69. *NOTE: Providers will be reporting to both ASD and APS.*

2. Criminal Act

Any serious illegal act, alleged or suspected, must be reported, including any act that warrants incarceration of a person enrolled in services. Any circumstance indicating a duty to warn must be reported. If it would violate professional ethics or federal law to make such a report, one is not required.

3. Destruction of Property

Including but not limited to fire, flood, breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation.

4. Medication Error

A medical error is a preventable adverse effect of care, whether or not it is evident or harmful to the person. This includes but is not limited to; administration of the wrong drug to the wrong person or in the wrong way or at the wrong time or wrong dose or wrong frequency or a missed dose. A

participant's refusal to take a medication is not considered an error and should be documented in the person's record.

5. **Medical Emergency**

A serious, life threatening, medical event or injury, for a person served, that requires immediate emergency evaluation by medical professionals.

6. **Missing Person**

A person enrolled in services who is identified as missing by law enforcement, the media, staff, family, caregivers, or other natural supports (unexplained absence).

A person served is considered "missing" if the person's housemate or support staff cannot locate him or her and there is reason to think that the person may be lost or in danger. A report is not required for people who live with unpaid caregivers or housemates (such as natural family), unless the caregiver or family requests assistance in locating the person or the person has been identified as missing by law enforcement.

7. **Potential Media Involvement**

Any incident, marked by seriousness or severity, that is likely to result in attracting negative public attention, or lead to claims or legal action against the State.

8. **Seclusion or Restraint**

CFC participant residing in an AFC home has the right to be free from any and all restraints. The use of any form of restraint of a CFC participant is strictly prohibited under this policy.

"Restraint" includes:

- **Mechanical restraint:** any items worn by or placed on the person to limit behavior or movement and which cannot be removed by the person. Mechanical restraints include devices such as mittens, straps, arm splints, harnesses, restraint chairs, bed rails and bed netting.
- **Physical restraint:** any method of restricting a person's movements by holding of body parts to keep the person from endangering self or others (including seclusion or physical escort to lead the person to a place he or she does not want to go).
- **Chemical restraint:** the administration of a prescribed or over-the-counter medicine when all the following conditions exist: the primary purpose of the medication is a response to problematic behavior rather than a physical health condition; and, the prescribed medicine is a drug or dosage which would not otherwise be administered to the person as part of a regular medication regimen; and, the prescribed medicine impairs the individual's ability to do or accomplish his or her activities of daily living (as compared to the individual's usual performance when the medicine is not administered) by causing disorientation, confusion, or an impairment of physical or mental functioning.

9. **Suicide attempt (or lethal gesture)** Death would likely result from the suicide attempt or gesture and the person requires medical attention.

10. **Untimely or Suspicious death**

D. Agency/Provider Reporting Procedures & Timeframe

The following process is required for all participants enrolled in the CFC Adult Family Care option, and CFC participants enrolled in Money Follows the Person in all settings.

1. Any CFC service provider that becomes aware of a critical incident listed above is required to complete a critical incident report (CFC 831) and submit it to ASD, as soon as possible, and no later than **48 hours of discovery of the incident**.
2. Reports shall be faxed to ASD: 802-871-3052 or scanned and emailed to the ASD Critical Incident email address within 48 hours of incident discovery.
3. If the reporter cannot access a fax machine or email within 48 hours, they must call (802)-871-3035 as soon as possible (ASAP) **within 48 hours** of discovery of the incident. ASD staff will document the incident while speaking with the Reporter. If ASD is not available to answer the CIR call, (after regular business hours or on the weekend) the reporter shall leave a voicemail message including at least their name and contact information and the person(s) involved in the incident. The reporter must submit a written report as soon as possible after the phone call.
4. Adult Protective Services: Pursuant to Vermont statute 33 V.S.A. Chapter 69, all Choices for Care service providers are mandated to report suspicion of adult abuse, neglect and exploitation to the Division of Licensing and Protection (DLP), Adult Protective Services (APS) <http://www.dlp.vermont.gov/protection>. Mandated reporters are required to submit a critical incident report to the Adult Services Division AND report **within 48 hours to APS** by calling 1-800-564-1612 or out-of-state call (802) 871-3326 or online at <http://www.dlp.vermont.gov/guidelines/report>.
5. For participants of the Adult Family Care option, the reporter of the incident shall also notify the participant's Authorized Agency **within 24 hours** of discovery of the incident.
6. For Adult Family Care option, the Authorized Agency shall notify the guardian, (private or public), case manager and home provider of any incident **within 24 hours** of discovery of the incident.
7. For non-Adult Family Care MFP participants, the reporter (if not the case manager) must notify the CFC case manager **within 24 hours** of discovery of the incident.
8. For non-Adult Family Care MFP participants, the case manager shall notify the legal guardian (private or public) and other appropriate service providers **within 24 hours** of discovery of the incident.
9. Licensed Providers: CFC providers that are licensed under the Vermont Home Health Agency Designation and Operation Regulations, Residential Care Home Licensing Regulations, Assisted Living Residence Licensing Regulations, and the Nursing Home Licensing and Operating Rule must also follow the applicable incident reporting criteria found in state regulation with the Division of Licensing and Protection <http://www.dlp.vermont.gov/regs>.
10. Internal Incident Reports: If the reporter works for an agency that has its own internal reporting requirement they must complete their internal process in addition to the ASD & APS reports.

E. DAIL/ASD Procedures & Timeframes:

1. When ASD receives an incident report during regular business hours, an ASD quality specialist will review the incident to determine if any action, remediation or improvement plan is needed and record the incident. ASD's follow-up response to each incident is based on multiple factors including but not limited to the individual's needs, the incident, actions taken and resolution to the incident.
2. When ASD quality specialist receives an incident report over the phone they will ask for all the information on Critical Incident Form (CFC 831).
ASD quality specialist will review the incident information to determine:
 - If the incident meets the CIR definition
 - If the incident has been resolved
 - If the incident includes suspected abuse, neglect or exploitation
 - If the incident includes suspected Medicaid fraud or abuse
 - If appropriate actions were taken
 - If additional information is required
 - If investigation and remediation is required
 - If the report was made in the required timeframe
 - If there are any additional concerns triggered by the incident (trends)
3. ASD quality specialist will contact agencies, providers, family or appropriate authorities or emergency services for any incidents in which the CFC participant is still missing or in need of immediate assistance.
4. ASD quality specialist will submit a report to APS for all incidents that include suspected abuse, neglect or exploitation **within 48 hours**.
5. ASD quality specialist will report all incidents that include suspected Medicaid fraud or abuse to Department of Vermont Health Access (DVHA) Program Integrity (PI) Unit (802.879.5900) **within 72 hours** of discovery of the incident report.
6. ASD quality specialist will contact appropriate individuals or agencies for additional information as necessary. ASD quality specialist may request an internal investigation report from the provider. ASD quality specialist may conduct an investigation incorporating the following information:
 - a. circumstances leading up to and culminating in the critical incident;
 - b. any current practice, procedure or factor involved in providing the service that contributed to the occurrence of the critical incident;
 - c. actions considered, developed or required as follow up to the critical incident
7. ASD Quality Specialist will review critical incident data to identify any repeat patterns, trends or concerns within **2 business days** of receipt of a report.
 - a. If there is a concern, the ASD Quality Specialist will follow up with the ASD Quality Improvement (QI) committee within **2 business days**.
 - b. The QI committee will review the information and determine if any actions are necessary within **2 business days** of receipt of the information.
 - c. If deemed necessary by the ASD QI committee a Critical Incident Improvement Plan may be requested from the provider which may include:

- i. Actions to be taken to prevent reoccurrences or improve response in the event of similar incidents;
 - ii. A date by which the actions will be taken;
 - iii. The AA or provider agency staff responsible for taking the actions.
 - iv. The ASD Quality Specialist will work in collaboration with the involved entities to ensure completion of a Critical Incident Improvement Plan.
8. ASD Quality Improvement Committee will conduct oversight of staff and 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. CHECK NUMBERING

Appendix I

CFC 706 08/13



Adult Services Division
Critical Incident Reporting Form

Reporting Criteria

The purpose of Critical Incident reporting is to document, evaluate and monitor certain **serious or severe** occurrences that affect the wellbeing of program participants. Choices for Care Participants utilizing the Adult Family Care Home and Money Follows the Person Program in all settings, are subject to the Adult Services Division Critical Incident process outlined in the Choices for Care Manual in Section V.14

<http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-highest-needs-section-v-14-critical-incident-reporting>

Definition

A Critical Incident is a serious or severe situation in which:

- Any actual or alleged event, incident or course of action involving the perceived or actual threat to a participant's health and welfare; or
- Any actual or alleged event, incident or course of action involving the perceived or actual threat to his/her ability to remain in the community.

Instructions:

Reports to ASD should be made within 48 hours of discovery of the incident via:

- a. faxed to ASD at (802) 871-3052 or
- b. scanned and emailed to the ASD Critical Incident email AHS.DAILASDCIR@state.vt.us
- c. Phone (802) 871-3035, when access to email or fax is not possible
- d. Pursuant to Vermont statute 33 V.S.A. Chapter 69, all Choices for Care service providers are mandated to report suspicion of adult abuse, neglect and exploitation to the Division of Licensing and Protection (DLP), Adult Protective Services (APS)
<http://www.dlp.vermont.gov/protection>. Mandated reporters are required to submit a critical incident report to the Adult Services Division AND report within 48 hours to APS by calling 1-800-564-1612 or out-of-state call (802) 871-3326 or online at <http://www.dlp.vermont.gov/guidelines/report>.
- e. CFC providers that are licensed under the Vermont Home Health Agency Designation and Operation Regulations, Residential Care Home Licensing Regulations, Assisted Living Residence Licensing Regulations, and the Nursing Home Licensing and Operating Rule must

also follow the applicable incident reporting criteria found in state regulation with the Division of Licensing and Protection <http://www.dlp.vermont.gov/regs>.

f. For participants of the Adult Family Care option, the reporter of the incident shall also notify the participant's Authorized Agency within 24 hours of discovery of the incident.

g. For Adult Family Care option, the Authorized Agency shall notify the guardian, (private or public), case manager and home provider of any incident within 24 hours of discovery of the incident.

h. For non-Adult Family Care MFP participants, the reporter (if not the case manager) must notify the CFC case manager within 24 hours of discovery of the incident.

i. For non-Adult Family Care MFP participants, the case manager shall notify the legal guardian (private or public) and other appropriate service providers within 24 hours of discovery of the incident.

Fax Completed Form to 802-871-3052 or Email to AHS.dailasdcir@state.vt.us

Participant's Information

First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Guardian:	<input type="text"/>
Guardian Phone:	<input type="text"/>
Choices for Care Program:	<input type="checkbox"/> Adult Family Care
	(Check all that apply) <input type="checkbox"/> Money Follows the Person

Reporter Information

Name:	<input type="text"/>
Agency:	<input type="text"/>
Email:	<input type="text"/>
Phone:	<input type="text"/>

Incident Information

Date of Incident:	<input type="text"/>
Time of Incident:	<input type="text"/>
Date Incident Discovered:	<input type="text"/>
Date Incident Reported to ASD:	<input type="text"/>
Law Enforcement Involved:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persons Present or Involved:	<input type="text"/>
Incident Location:	<input type="text"/>

Type of Incident (Identify Primary Type of Incident)

Criminal Act:	<input type="checkbox"/>	Potential Media Involvement:	<input type="checkbox"/>
Missing Person:	<input type="checkbox"/>	Seclusion or Restraint:	<input type="checkbox"/>
Medication Error:	<input type="checkbox"/>	Destruction of Property:	<input type="checkbox"/>
Medical Emergency:	<input type="checkbox"/>	Untimely or Suspicious death:	<input type="checkbox"/>
Suicide Attempt:	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Alleged Abuse Neglect or Exploitation:		<input type="checkbox"/>	
Must Report to APS within 48 Hours			

Describe the Incident

Actions Taken (Check all that apply)

Re-assessment:	<input type="checkbox"/>	Emergency Services Utilized:	<input type="checkbox"/>
Care Plan Reviewed:	<input type="checkbox"/>	Medical Treatment Required:	<input type="checkbox"/>
Care Plan Revised:	<input type="checkbox"/>	PT/OT Referral:	<input type="checkbox"/>
Backup Plan Revised:	<input type="checkbox"/>	Increased Case Management:	<input type="checkbox"/>
Increased Visits:	<input type="checkbox"/>	Skilled Nursing Ordered:	<input type="checkbox"/>
Increased CM Hours:	<input type="checkbox"/>	Physician Follow -up:	<input type="checkbox"/>
No Action Taken:	<input type="checkbox"/>	Negotiated Risk Contract:	<input type="checkbox"/>
Hospital Admission:	<input type="checkbox"/>	Nursing Home Admission:	<input type="checkbox"/>
Admit Date:	<input type="checkbox"/>	Admit Date:	<input type="checkbox"/>
Discharge Date:	<input type="checkbox"/>	Discharge Date:	<input type="checkbox"/>
Other:	<input type="text"/>		

Notifications (Enter Date)

Guardian:	<input type="text"/>	Adult Protective Services:	<input type="text"/>
Case Manager:	<input type="text"/>	Authorized Agency:	<input type="text"/>
Other:	<input type="text"/>		

Incident Review

Was the Incident Preventable? Yes No

What actions could you, or others do, to prevent future incidents?