

Choices for Care
§ 1115 Waiver Renewal Application
October 2010 – September 2015

Submitted by
The State of Vermont
Department of Disabilities, Aging and Independent Living

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Section 1: Demonstration Summary and Objectives

Operating since October 2005, the State of Vermont's 1115 Waiver demonstration project "Choices for Care" has played a critical role in providing Vermonters with equal access to innovative, quality long-term care options consistent with individuals' expressed preferences and needs. Since its implementation, the waiver has made fundamental changes to how Vermont provides long-term care services and supports to low-income seniors and people with disabilities. Choices for Care has increased the number of long-term care settings and service options available and has expanded access to long-term care services for individuals who do not meet eligibility requirements under current Medicaid and home and community-based services (HCBS) waivers.

The initial five-year term of the Choices for Care waiver will expire on September 30, 2010. With the approval of the Centers for Medicare and Medicaid Services (CMS), it is Vermont's intent to continue and expand on the successes that it has achieved by extending the waiver for an additional five years.

Eligibility

Choices for Care is administered by the Department of Disabilities, Aging and Independent Living (DAIL), within the Vermont Agency of Human Services. This project provides long-term care services to elderly or physically disabled Vermont adults who are found eligible by DAIL.

To be eligible for the program, individuals must be Vermont residents who are age 65 years or older, or those age 18 and older whose primary needs are the result of a physical disability. The waiver includes individuals in nursing homes, HCBS, Enhanced Residential Care settings, and PACE (Program for All-Inclusive Care for the Elderly). Choices for Care excludes children¹, individuals residing in Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD), individuals in mental illness and traumatic brain injury waivers, and other limited exclusions.

Choices for Care established three levels of need for long-term services and supports, including an "expansion group" intended to serve more Vermonters who would not be eligible for traditional Medicaid long-term care services. The type, setting, and amount of services an individual receives depend on that individual's choices as well as level of need:

- *Highest Need Group* – Individuals in the "Highest Need Group" are entitled to either nursing facility or home and community-based care. All participants in this group must

¹ Exceptions are made for a small number of people under the age of 18 who need nursing home services, which are available only through Choices for Care.

meet the financial eligibility criteria for Vermont Long-Term Care Medicaid.^{2,3} Individuals are placed in the Highest Need Group if they meet specific functional criteria, including the need for extensive or total assistance with toileting, bed mobility, eating or transferring; if they have a severe impairment with decision-making or have a moderate impairment and exhibit certain behaviors; or if they meet certain other criteria.

- *High Need Group* – The “High Need Group” consists of individuals whose functional limitations make them eligible for nursing home care, but do not meet the level of care criteria for the Highest Need Group. In addition to meeting clinical standards established for the Demonstration, High Need Group individuals must also meet the existing long-term care financial Medicaid eligibility criteria.⁴ While members of this group are “entitled” to long-term care services, they are served to the extent that funds are available.
- *Moderate Need Group* – This expansion group includes individuals who do not meet current long-term care eligibility criteria, but have unmet needs that put them at risk. Individuals in the “Moderate Need Group” are assessed and provided with only those services (not covered by other funding sources) necessary to help maintain their well being and independence. Services include homemaker services, case management, and adult day care. Individuals in this group are served to the extent funds are available after serving all eligible individuals in the Highest and High Need Groups.

Care Settings

Choices for Care has been designed specifically to help elders and younger adults with physical disabilities to live as independently as possible for as long as possible, in the settings of their choice. Services are covered, based on their inclusion in an approved care plan, at the level called for in that plan:

- *Home-Based Supports* – This includes personal care, respite, companion, adult day, and case management services to help people remain in their homes and communities.
- *Enhanced Residential Care* – 24-hour care is provided in licensed Level III Residential Care Homes and Assisted Living Residences authorized to care for residents with nursing home level of care needs.

² Exceptions are made for people who are eligible for Medicaid under community rules, and need rehabilitation services in a nursing home setting.

³ Demonstration participants electing home-based services may retain up to \$10,000 in resources, which helps to ensure that they can maintain their home. Individuals electing nursing facility or other residential care may retain up to \$2,000 in resources.

⁴ Ibid. 2 and 3.

- *Nursing Facility Services* – 24-hour care is provided in licensed, certified Nursing Facilities.
- *Flexible Choices* – Home-based participants may convert their home-based plans of care to a dollar-equivalent budget allocation. Working with a consultant, participants develop a spending plan for their allocations, allowing them more flexibility in purchasing care and services that meet their individual needs, goals, and preferences.
- *Program for All-Inclusive Care for the Elderly (PACE)* – An integrated health care delivery system for frail individuals 55 years and older that provides all Medicare and Medicaid acute, primary, and long-term care needs.

Program Objectives

The goal of Choices for Care is to provide Vermonters with individual choice and equal access to long-term care options in the community and nursing facilities. This is intended to prevent unnecessary use of nursing facility care by elders and adults with disabilities who have functional impairments. Choices for Care’s main objectives are as follows:

- Increase access to home and community-based services;
- Expand the range of community-based service options; and
- Provide elders and adults with physical disabilities who are at potential risk of future nursing facility placement with early intervention services.

By offering a range of innovative service options and earlier intervention, Vermont has intended to:

- Ensure enrollee satisfaction with the long-term care services received;
- Reduce utilization of institutional care; and
- Control overall costs of long-term care.

Figure 1.1 on the following page provides an overview of the Choices for Care Demonstration outcomes, as described in the evaluation plan:

Figure 1.1 – Desired Outcomes

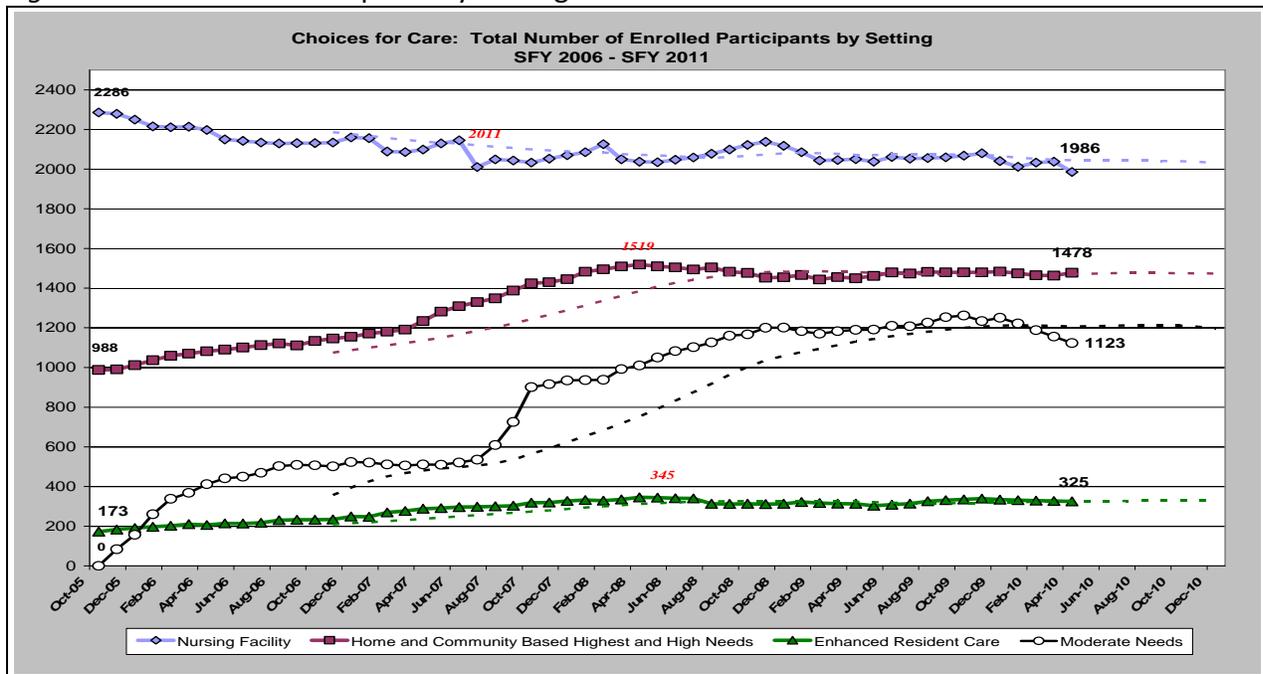
Short-term Desired Outcomes (to be achieved within 1-5 years)	
<i>1. Information Dissemination</i>	Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant’s expressed preference and need
<i>2. Access</i>	Participants have timely access to long-term supports in the setting of their choice
<i>3. Effectiveness</i>	Participants receive effective home and community-based services to enable them to live longer in the community
<i>4. Experience of Care</i>	Participants have positive experiences with the types, scope, and amount of Choices for Care services
<i>5. Quality of Life</i>	Participants report that their quality of life improves
<i>6. Applicants List (Waiting List) Impact</i>	Choices for Care applicants who meet the high needs special circumstances criteria have equal access to service regardless of the setting of their choice
<i>7. Budget Neutrality</i>	Medicaid’s cost of serving Choices for Care participants is equal to or less than would have been spent under the previous Medicaid and HCBS waiver system
Long-term Desired Outcomes (to be achieved after the initial five years of the project)	
<i>8. Public Awareness</i>	Vermont’s general public is aware of the full range of long-term care settings for persons in need of long-term care and have enough information to make decisions regarding long-term care
<i>9. Health Outcomes</i>	Participant’s medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed

Major Accomplishments

Vermont has made tremendous progress towards achieving the waiver’s objectives and outcomes. The following highlights some of the major accomplishments of the Choices for Care Demonstration.

Choices for Care has led to a “rebalancing” of the settings where individuals receive services and where Vermont spends its resources for long-term services. Although nursing facilities continue to be the most frequent setting for participants, Vermont has significantly increased the number of Vermonters receiving community-based services since implementing Choices for Care, while reducing the number of individuals receiving services in nursing homes. Figure 1.2 on the following page shows enrollment totals by care setting.

Figure 1.2 – Enrolled Participants by Setting



Data source: DAIL/DDAS SAMS Database

Findings also show that Choices for Care served more individuals than it would have under the previous Medicaid and home and community-based services waiver system. To the extent funds are available, individuals who do not meet traditional long-term care eligibility criteria receive services necessary to help maintain their well being and independence.

A major objective of the program is to expand service options for community-dwelling participants. Choices for Care has expanded Vermont’s range of services by providing new community-based options for participants:

- *Flexible Choices* – Based on the belief that consumers and their families know how best to meet their own needs, Flexible Choices offers consumers an allowance for consumer/surrogate-directed care. Allowances are based on participants’ needs and the value of their home-based service plan. Consumers, or their representatives, work with a Flexible Choices consultant to develop a service plan and budget that uses the allowance in a way that best meets their needs. A Fiscal Intermediary Services Organization helps consumers manage payroll and related tasks for workers who are hired and for other costs associated with care at home.
- *Expansion of PACE sites* – Choices for Care has supported the opening of two PACE sites, the first in Vermont and among the most rural in the United States. Care is provided or coordinated by an interdisciplinary team. The individual receiving care is a member of the team, along with his or her physician, nurses, therapists, and other caregivers. The team is located at a PACE site that includes a physician’s office and an adult day center.

Once enrolled in the program, PACE takes responsibility for managing all Medicare and Medicaid services including physical care, mental health care, and long-term care.

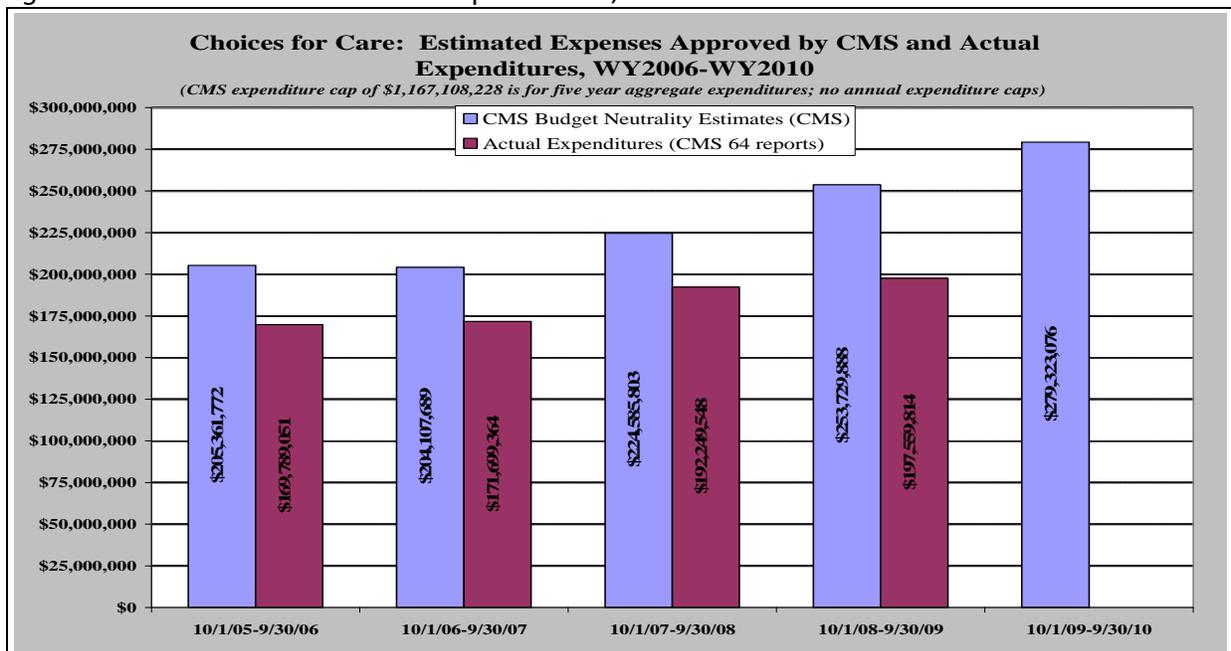
- *Spousal reimbursement* – Choices for Care recognizes that there are times when care is most effective and satisfying to an individual when provided by his or her spouse. Spouses may be eligible for payment as personal care attendants to provide care to Choices for Care participants.

All these services enrich the range of options available to participants who choose a community setting. Participants have reported having positive experiences with the types, scope, and amount of Choices for Care services. Providing more choice options has resulted in high levels of overall satisfaction and quality of life survey responses for participants receiving care in a community setting. Over 90 percent of participants in community settings consistently rated their experiences with care as “excellent” or “good.” Satisfaction rates have increased over the course of this Demonstration.

Medicaid’s cost of serving Choices for Care participants is equal to or less than would have been spent under the previous Medicaid and HCBS waiver services system. The project has stayed below its CMS projected annual cap for expenditures, while shifting spending more towards community-based spending. This has enabled Choices for Care to use available funds to serve more individuals than would have been possible without the waiver. Choices for Care also has allowed the State to keep spending within annual appropriations.

Actual long-term care costs have been within the approved total and less than projected for each year as illustrated in Figure 1.3 below.

Figure 1.3 – Estimated and Actual Expenditures, WY 2006 – WY 2010



Future Goals

Through the waiver extension, Vermont will continue to strive towards the goals established for Choices for Care. One of the goals of Choices for Care is to help Vermonters access long-term care services when they are needed. An indicator of success in achieving this goal is the time required to process individual applications. Medicaid eligibility decisions are made within one month for about 62 percent of applications, within two months for about 71 percent of applications, and within three months for about 86 percent of applications. These percentages are slightly higher than the initial years of Choices for Care, suggesting that Medicaid eligibility determinations generally are completed more quickly. However, the program is seeking additional ways to reduce the time required to process applications.

Another indicator of access to services is the number of individuals on waiting lists. Prior to Choices for Care, home and community-based and enhanced residential care applicants often were placed on waiting lists. The number of people on waiting lists fell from 240 to 0 during the initial implementation of Choices for Care, when all individuals in the Highest Need Group became entitled to the service of their choice. Although the current economic climate has reduced state revenues substantially, recent expenditure trends in Choices for Care have allowed people to be enrolled in the High Need Group on a month-to-month basis. While the creation of Moderate Need Group services improved access to adult day and homemaker services, the recent (November 2009) freeze on new enrollment in the Moderate Need Group has reduced the number of people served, and is expected to lead to increases in the number of people on waiting lists.

While continuing to work towards these short-term outcomes, Vermont will attend to the long-term outcomes of public awareness and health outcomes. DAIL has begun to actively discuss ways to increase general public awareness of long-term care service and financing options, including development of long-term care insurance partnerships and/or a long-term care awareness campaign. DAIL is also engaged in discussions of how to expand the Vermont “Blueprint for Health” health management practices into Choices for Care.

Vermont is in the process of developing additional innovative options to best meet the needs of individuals seeking long-term care within a community-setting, including:

- *Adult Foster Care* – Most people prefer to receive services in a community-based setting. However, some people need intermittent “24-hour” care and are admitted to nursing homes to access this care. Adult foster care would provide an alternative community-based service option for people who need this type of ongoing intermittent care, and the Vermont legislature has directed DAIL to pursue this. Care is provided to a maximum of two individuals by an approved community-based provider in a home setting.
- *New Payment Methods* – The Vermont legislature has directed the Agency of Human Services to focus on more flexible, performance-based service payments. The current

focus is on developing new payment methods (including tiered rates, bundled rates, and case rates) that both allow and encourage more flexibility in achieving positive outcomes for individual consumers. This would offer more flexibility to consumers in the selection of services to best meet their needs, streamline the payment system to providers, and remain cost neutral to the State.

- *Presumptive Eligibility* – DAIL will re-examine the use of state funds to expedite access to services for clinically eligible individuals who appear to meet financial eligibility criteria while their full financial eligibility is under review. The goal of this approach is to expedite access to services, increase the use of home and community based services, and improve outcomes for consumers without creating new federal financial commitments.

Section 2: Public Notice and Renewal Notification

Vermont has obtained public input regarding the continuation of Choices for Care, consistent with the 1115 waiver notification requirements.

Public Notice

The Vermont Legislature required in the SFY 2009 Appropriations Bill that “the department convene a working group from its advisory council for the purpose of providing input on the advisability of seeking renewal of the waiver and how with any new waiver there can be timely reporting to providers and consumers on reinvested savings.” Beginning in September 2008, the DAIL advisory board convened monthly to provide input on the advisability of seeking renewal of the waiver and to identify elements for program improvement. The advisory board expanded its meetings to include providers, consumers, and advocates to discuss the waiver and its renewal.

In October 2009, the advisory board invited advocates, providers, and the public to attend a meeting to provide specific input into the request for an extension. A summary of the opinions expressed by attendees of the public hearing is provided in Appendix A.

The advisory board took the comments into consideration when it completed its work, developing the following list of possible improvement for Choices for Care:

- 24-hour care (a.k.a. “adult foster care”) to provide more intensive support;
- HCBS “case rates” to support more consumer choice and flexibility while reducing workload for case managers and state staff;
- “Flexible Choices” option for consumers in the Moderate Need Group to improve access and support more consumer choice and flexibility;
- Consider additional organizations (other than home health agencies) to provide personal care, respite care, and companion services;
- Expand Enhanced Residential Care (ERC) capacity;
- Integrate evidence based practices for people with chronic conditions; and
- Explore the development of “communes” where consumers can support each other and share support services.

Tribal Government Notification

DAIL is cognizant of the requirement to notify in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within Vermont of the State’s intent to submit a waiver renewal request.⁵ No federally recognized Tribal Governments exist within Vermont. Therefore, no tribal notifications were made, nor were comments regarding the waiver renewal received from Tribal Governments.

⁵ As provided by Presidential Executive Order 13175 of November 6, 2000 and in accordance with SMDL #01-024.

Section 3: Special Terms and Conditions

Over the course of this demonstration period, Vermont has complied with each of the Special Terms and Conditions (STCs) that govern Choices for Care. Figure 3.1 on the following page contains the STCs for the award of the Choices for Care Demonstration request submitted on October 7, 2003. Figure 3.1 also highlights the compliance efforts of the State. Appendix B contains a draft of proposed STCs for the renewal period.

Figure 3.1 Special Terms and Conditions

Subject Area	Special Terms and Conditions	Compliance/Status
I. General Program Requirements	1. Extension or Phase-out Plan. The State will discuss demonstration extension plans with CMS at least 18 months prior to demonstration expiration, and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan must be submitted to CMS to review and consider for approval.	A letter from the Governor requesting an extension was submitted to CMS in September 2009.
	2. State Right to Amend Demonstration. The State may amend this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for amending the demonstration. Any modifications by the State to the Long-Term Care Plan demonstration must be submitted in writing and are subject to prior approval by CMS.	The State does not have any amendments at this time.
	3. CMS Right to Suspend or Preclude the Demonstration Implementation. The CMS may suspend or preclude Federal Financial Participation (FFP) for State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.	The Choices for Care program was not suspended or precluded from implementation by CMS.
	4. State Right to Terminate or Suspend Demonstration. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.	The State has no plan to terminate or suspend the Choices for Care Demonstration at this time.
	5. CMS Right to Terminate or Suspend the Demonstration Operation. During demonstration operation, CMS may suspend or terminate FFP for any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination. The effective date of such action shall not be fewer than 45 days from the date of notice. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and authority for pending FFP for costs not otherwise matchable or to withdraw waivers or authority for costs not	The Choices for Care program has not been terminated or suspended during operations by CMS.

Subject Area	Special Terms and Conditions	Compliance/Status
	<p>otherwise matchable at any time if it determines, after good faith consultation with the State, that granting or continuing the waivers or authority for costs not otherwise matchable would no longer be in the public interest. If the waiver or authority for costs not otherwise matchable is withdrawn, CMS will be liable only for normal closeout costs.</p>	
II. General Reporting Requirements	<p>6. Monthly Progress Calls. During the first 6 months of operation, CMS and the State will hold monthly calls to discuss demonstration progress. After 6 months of operation, CMS and the State will determine the appropriate frequency of progress calls.</p>	<p>The State has complied.</p>
	<p>7. Quarterly & Annual Progress Reports. The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. The CMS reserves the right to request the annual report in draft. The reports will address, at a minimum:</p> <ul style="list-style-type: none"> • a discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures); • a discussion of the State’s progress in completing Quality Assurance and Quality Improvement Plan activities; • notable accomplishments; and • problems/issues that were identified and how they were solved. 	<p>The State submitted quarterly progress reports within 60 days of the end of the quarter discussing as appropriate, events occurring during the quarter that affect the Demonstration population, the State’s progress in quality assurance and quality improvement activities, notable accomplishments, and identified and solved problems. Quarterly Data Reports to CMS present recent data that documents the status and progress of Choices for Care.</p> <p>Quarterly progress reports were submitted to CMS through June 2007, after which CMS agreed to semi-annual reports. All reports are on file with CMS.</p> <p>Reports are available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-reports-cms/publications-cfc-cms-reports</p> <p>The State publishes quarterly reports describing enrollment trends and numbers by setting and applicants list. These reports are available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/cfc-qrtrly-data-rpts/cfc-quarterly-data-reports</p>

Subject Area	Special Terms and Conditions	Compliance/Status
	<p>8. Final Demonstration and Evaluation Report. At the end of the demonstration period, a draft final report will be submitted to CMS for comments. CMS' comments shall be taken into consideration by the State for incorporation into the final report. The final report with CMS' comments is due no later than 180 days after the termination of the project.</p>	<p>The Choices for Care Demonstration is in progress. The State secured a contract with the University of Massachusetts for an initial three-year contract period to perform an independent evaluation, including policy briefs, consumer survey analysis, and overall evaluation report. The State issued a Request for Proposal to continue an independent evaluation into the Demonstration's extension period, and again selected the University of Massachusetts through this process.</p>
<p>III. Legislation</p>	<p>9. Changes in the Enforcement of Laws, Regulations, and Policy Statements. All requirements of the Medicaid program expressed in Federal laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.</p> <p>If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).</p> <p>10. Changes in Federal Law Affecting Medicaid. The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.</p> <p>If the new law cannot be linked specifically with program components that are or</p>	<p>The State is compliant.</p> <p>DAIL will work with CMS to discuss the impact of the Patient Protection and Affordable Care Act (PPACA) of 2010 and implement any changes as necessary to be in compliance.</p>

Subject Area	Special Terms and Conditions	Compliance/Status
	<p>are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without-waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.</p> <p>11. Amending the Demonstration. The State may submit an amendment for CMS consideration requesting exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration program do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).</p>	
<p>IV. Assurances</p>	<p>12. Preparation and Approval of Operational Protocol. Prior to service delivery under this demonstration, an Operational Protocol document, which represents all policies and operating procedures applicable to this demonstration, will be prepared by the State and approved by CMS. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval. <i>Requirements and required contents of the Operational Protocol are outlined in Section V of these Special Terms and Conditions.</i></p> <p>13. Person-Centered Planning Process. The State agrees to use a person-centered planning process to identify participants' and applicants' long term care needs and the resources available to meet these needs, and to provide access to additional care options, including the choice to use spouse caregivers, and to access a prospective monthly cash payment.</p> <p>14. Adequacy of Infrastructure. Adequate resources for implementation, monitoring activities, and compliance to the Special Terms and Conditions of the demonstration will be provided by the State. It is the goal of the demonstration to serve more people, not fewer, by allowing and encouraging more home-based services, thus freeing up funds to serve more people. Through the State's 10 year plan, each year the State will add resources to the long term care system equivalent to a minimum of 100 additional Home and Community Based 'slots'. This indicates recognition would be required in order to accommodate a growing</p>	<p>The State is not requesting any amendments to the Choices for Care Demonstration.</p> <p>The State has complied. The Protocol is available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-documents/1115-ltc-demonstration-waiver-operational-protocol-with-appendices.pdf</p> <p>The State is compliant.</p> <p>The State is compliant.</p>

Subject Area	Special Terms and Conditions	Compliance/Status
	population.	
	15. Changes Resulting from Implementation of the Medicare Modernization Act (MMA). The State agrees to a modified budget limit developed by CMS that will result from implementation of the MMA. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. The MMA makes the Part D Drug Benefit effective on January 1, 2006.	The State is compliant.
	16. Changes to Level of Care Criteria. The State agrees to submit, for CMS review and approval, any current or proposed assessment instruments, policies, and procedures for determining the level of care for demonstration participants and applicants.	The State is compliant.
	17. Maintenance of Effort. The State agrees that annual expenditures for each year of the demonstration shall be at least the same level of total combined Medicaid expenditures for nursing home services and for the two 1915(c) Waivers in place in Vermont during the base year for the demonstration, SFY 2003. This total figure is \$120,236,519 per year. The State also agrees that the number of individuals fully served under the demonstration shall not decrease from the base year for the demonstration, SFY 2003. This total figure is 3201 participants per year.	The State is compliant. Please refer to Section 6 on Budget Neutrality.
	18. Participant/Applicant Satisfaction and Waiting List Monitoring. Participants and applicants on waiting lists will be included in demonstration Beneficiary Surveys, Quality Assurance/Quality Improvement activities and evaluation activities. The State agrees to report on the status of the waiting list and the status of participant/applicant satisfaction surveys, Quality Assurance/Quality Improvement activities and evaluation activities during monthly progress calls between CMS and the State and in quarterly/annual reports.	The State is compliant.
	19. Prioritization of Enrollment. The State is reserving a minimum of \$1.7 million per year for provision of services to the Moderate Need group. Medicaid eligibles in the Moderate Need group must be served prior to expansion eligibles. Should a waiting list for long-term care services develop, the State agrees that individuals entitled to long-term care services will be enrolled in the long-term care program before persons with lighter care needs, according to a prioritization process described in the Operational Protocol. Specifically, participants receiving services currently will continue to receive services before participants and applicants in the Highest Need group; participants and applicants in the Highest Need group will receive services before participants and applicants in the High	In order to correctly serve individuals under the Terms and Conditions of the Choices for Care waiver, the State found it necessary to freeze the Moderate Needs Program beginning in November 2009. Additionally, any Moderate Needs funds that will not be needed to support enrolled participants for the remainder of the year will be used to meet the needs of High Needs individuals. A process has been put into place to establish prioritization as described in the Operational Protocol and Choices for Care

Subject Area	Special Terms and Conditions	Compliance/Status
	Need group; and participants and applicants in the High Need group will receive services before participants and applicants in the Moderate Need group.	Regulations to serve individuals on the High Needs Applicant List. Choices for Care providers were notified of that process and any further action that will need to be taken in future correspondence.
	<p>20. Restricting Choice of Providers. The State must provide access to nursing facility services to all Medicaid-eligible participants who meet the entitlement criteria established under the demonstration and desire nursing facility placement. If the State pursues selective contracting, the State must submit, for CMS review and approval, a description of the process for selecting providers of nursing facility services and allocating nursing facility beds. The State must demonstrate that the process used to select providers of nursing facility services and to allocate Medicaid reimbursed, nursing facility beds is consistent with the requirements of section 1923 and is consistent with access, quality, and efficient and economic provision of care and services for all participants needing nursing facility services including special regard to access to services for individuals with complex long-term care needs.</p> <p>CMS must review and approve readiness, before the State implements the selective contracting process. The CMS review will include, but is not limited to, a review of provider contracts, State legislative provisions, the public notice process, interviews with nursing facility providers, long-term care ombudsmen, Area Agencies on Aging, and participant advocates.</p>	The State is compliant.
	<p>21. Eligibility/Enrollment. The State agrees to submit, for CMS review and approval, a description of the population of individuals eligible for the demonstration (and eligibility exclusions), including plans for population phase-in.</p> <p>The State agrees to continue to provide nursing facility services and Home and Community-Based Services (HCBS) to participants receiving these services prior to implementation of the demonstration, in nursing facilities and through the 1915(c) Aged and Disabled and Enhanced Residential Care Home and Community-Based Services waiver programs. Participants will continue to maintain pre-demonstration service options if their level of care (using pre-demonstration criteria) remains the same or increases and their financial eligibility is maintained.</p>	The State is compliant.
	22. Self-Directed Supports. The State agrees to provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participants' compliance with laws pertaining to employer	The State is compliant. The Flexible Choices pilot has become an option within the Choices for Care Demonstration. Flexible Choices offers consumers

Subject Area	Special Terms and Conditions	Compliance/Status
	<p>responsibilities and provision for back-up attendants as needs arise. The State agrees to make background checks on employees available to participants, upon request, and provide guidance to participants on the results of checks.</p> <p>In addition, the State will provide adequate resources to support participants in securing and managing their personal care service providers and hours, including but not limited to the following self-directed supports:</p> <p>A. Self-Directed Supports</p> <ol style="list-style-type: none"> 1. A fiscal agent/intermediary is available to all participants; 2. Assistance in locating a provider; 3. An assurance of the right to hire, fire and supervise the work of their providers; and, 4. Consultants are available to participants to conduct assessments and annual reassessments, inform participants of their rights and responsibilities, monitor the quality of each participant's services, assist participants with learning their roles and responsibilities as "employer" and to understand the roles and responsibilities of their providers, act as points of contact if participants have questions or their care providers are unavailable, oversee the funds provided to participants, ensure that service allocations and services provided are consistent with the assessment and care plan, and make referrals to other community resources when participants' care needs exceed the scope of services or hours permitted under the demonstration program. <p>B. In addition to the above supports, the State agrees to the following:</p> <p>1. Assistance of a Proxy. This demonstration is designed to assist individuals who are capable of directing their own care. Individuals who are not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.</p> <p>2. Supplant Services. Cash payments provided under this demonstration program</p>	<p>an allowance, which is based on their needs and the value of their Choices for Care Home Based Service Plan. Participants work with a Flexible Choices consultant to develop a budget to use that allowance in a way that best meets their needs.</p> <p>Additional information about the program and online resources available to participants may be found at: Flexible Choices pilot: http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-flexible/policies-cfc-flexible-documents/fc-sec-iv-12-jan2007 http://www.ddas.vermont.gov/ddas-publications/publications-cfc/choices-for-care-employer-handbook</p>

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	do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.	
	<p>23. Independent Advocate.</p> <ul style="list-style-type: none"> • An independent advocate or advocacy system is available to all participants and applicants in the demonstration program, including access to area agency on aging advocacy, legal services and the long-term care ombudsman. • The Medicaid Fair Hearing process is available to all demonstration participants and applicants. 	<p>The State is compliant. The long-term care Ombudsman Program was expanded to provide support and advocacy to consumers.</p> <p>In addition to the Medicaid Fair Hearing process, participants may seek the DAIL Commissioners hearing process.</p>
	<p>24. Quality Assurance and Quality Improvement (QA/QI). The Vermont Agency of Human Services will design and implement an overall QA/QI plan that effectively assures the health and welfare of program participants and applicants and continuous improvement in the demonstration program. The QA/QI system will be phased in and operational no later than three months after the start date of the demonstration. The State will provide a timeline for implementing the plan. The QA/QI plan will be consistent with the CMS Home and Community-Based Services Quality Framework and, at a minimum, include the following:</p> <p>A. A plan for discovery, remediation, and improvement; and</p> <p>B. A protocol for reviews, periodic home visits, and data collection; and plans to monitor implementation of the QA/QI plan.</p>	<p>The State has complied. A copy of the QA/QI plan is available online at: http://www.ddas.vermont.gov/ddas-policies/policies-qmu/policies-qmu-documents/qm-plan</p>
	<p>25. Cost sharing/Co-payments. State agrees to maintain State Plan cost-sharing and co-payment provisions for the Highest Need and High Need groups. Should cost-sharing and co-payments be instituted for the Moderate Need (expansion group), the annual aggregate cost-sharing may not exceed five percent of annual household income.</p>	<p>The State is compliant.</p>
	<p>26. Notification to Program Participants. The State agrees to notify demonstration participants, including current eligibles receiving services through 1915(c) programs and nursing facility services, regarding eligibility changes to be implemented under the Long-Term Care Plan demonstration, including, but not limited to, their enrollment into a section 1115 research and demonstration program. The notification to participants must meet the provisions of 42 CFR 431.210. Participants will be notified no later than 30 days prior to their transition to the Long Term Care Plan demonstration. The State agrees to notify CMS 30 days in advance, before terminating the 1915(c) programs, in accordance with the</p>	<p>The State has complied.</p>

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	requirements of 42 CFR 441.307.	
	27. Presumptive Eligibility. The State agrees to maintain current financial responsibility for the cost of services for participants found to be ineligible for Medicaid services and agrees not to request Federal financial participation for these expenditures.	The State is compliant.
	28. Room and Board. The State agrees to submit only support services claims for Enhanced Residential Care and assures CMS that room and board will not be billed.	The State is compliant.
	29. Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services. The State agrees to develop systems to track and report expenditures for CRT Services to participants with severe and persistent mental illness. Expenditures for CRT mental health services will be included under the budget neutrality agreement for the Vermont Health Access Plan section 1115 demonstration. All other expenditures will be included under the budget neutrality agreement for the Long-Term Care Plan section 1115 demonstration for participants who are also enrolled in the Long-Term Care demonstration.	The State is compliant.
	<p>30. Evaluation and Monitoring Design. The State will conduct an evaluation of the impact of the Long-Term Care demonstration on participants and applicants. The State acknowledges the importance to CMS of an evaluation to the operation, quality improvement and possible modifications to innovative demonstration initiatives. The evaluation will, at a minimum:</p> <ul style="list-style-type: none"> • Identify a set of measures that may be the best predictors of individuals at risk for institutional placement; • Determine the cost effectiveness of the overall long-term care program to furnish a comprehensive package of home and community-based services to individuals, based on their specific needs, as compared to the current system; • Assess the effect of the demonstration on delaying the need for nursing facility care; • Determine the effect of the demonstration and its policies on participant satisfaction; • Determine the effect of the demonstration and its policies on the array and amount of services available in the community; • Determine the effect of the demonstration and its policies on nursing facility census and acuity levels; and, • Determine the effect of the demonstration on the level of knowledge in the community with respect to long-term care resources, including Medicaid. 	<p>The State secured a contract with the University of Massachusetts for an initial three-year contract period to perform an independent evaluation, including policy briefs, consumer survey analysis, and overall evaluation report. The State issued two Requests for Proposals to obtain an independent evaluator through the Demonstration’s extension period and an independent contractor to develop and conduct consumer satisfaction surveys.</p> <p>Evaluation and consumer survey reports are available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys</p>

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	<p>31. Independent Evaluation. The State agrees to fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent Federally-funded evaluation of the demonstration program.</p>	The State is compliant.
	<p>32. Budget Neutrality. The cost of services provided during the demonstration will be no more than 100 percent of the cost to provide Medicaid services without the demonstration.</p>	The State is compliant. Please refer to Section 6 on Budget Neutrality.
	<p>33. Public Notice Requirements. The demonstration complies with public notice requirements as published in the <i>Federal Register</i>, Vol. 59, No. 186 dated September 29, 1994, (Document number 94-23960) and Centers for Medicare & Medicaid Services requirements regarding Native American Tribe consultation.</p>	The State is compliant.
<p>V. Operational Protocol</p>	<p>34. Operational Protocol Timelines and Requirements. The Operational Protocol will be submitted to CMS no later than 60 days prior to program implementation. CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the Special Terms and Conditions, those issues being necessary to approve the Operational Protocol.</p> <p>Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, will be submitted for review by CMS. The State will submit a request to CMS for these changes no later than 45 days prior to the date of implementation of the change(s).</p>	The State is compliant.
	<p>35. Required Contents of Operational Protocol:</p> <p>a. Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details such as a timeline for initiating tasks prior to and post implementation, including steps, estimated time of completion, and who will be responsible for the tasks.</p> <p>b. Reporting Items. A description of the content and frequency of each of the reporting items as listed in the Special Terms and Conditions Section II and Attachments A and C of this document.</p> <p>c. Implementation of MMA Drug Benefit. A description of how demonstration participants will be identified who are eligible for the MMA Drug Benefit and how</p>	The State has complied. The Protocol is available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-documents/1115-ltc-demonstration-waiver-operational-protocol-with-appendices.pdf

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	<p>participants will be informed about the benefit. In addition, the State agrees to provide a description and timeline for adjusting the financial reporting system to reflect changes in the treatment of pharmacy charges for participants who are eligible for both Medicare and Medicaid.</p> <p>d. Reporting on Participants Receiving CRT Services. A description of the systems for tracking and reporting on expenditures for Community Rehabilitation and Treatment Services for participants with severe and persistent mental illness. Describe how expenditures for CRT will be included under the budget neutrality agreement for the Vermont Health Access Plan section 1115 demonstration. All other expenditures will be included under the budget neutrality agreement for the Long-Term Care Plan section 1115 demonstration for participants who are also enrolled in the Long-Term Care demonstration.</p> <p>e. Reporting on Participants Who Would be Included in PACE Vermont. A description of the plan for implementing the Program of All-inclusive Care for the Elderly (PACE) including a description of how program expenditures would be reported within the Long-Term Care Plan demonstration. A separate PACE provider application will be submitted to CMS for review and approval per statute and regulations.</p> <p>f. Medicaid Fair Hearing. The State agrees to submit, for CMS review and approval, a protocol for resolving disagreements between the State and participants and applicants regarding eligibility for demonstration services. In addition, the State agrees to inform all demonstration participants and applicants about the Medicaid Fair Hearing process. If Fair Hearing policies differ from non-demonstration Medicaid, then provide a description of the policies that will be in place in the demonstration and how the process will be monitored. A plan for informing participants and applicants about the steps the Medicaid Fair Hearing policy.</p> <p>g. Outreach/Marketing/Education. A description of the State's outreach, marketing, education, staff training strategy/schedule. NOTE: <i>All marketing materials must be reviewed and approved by CMS prior to use.</i> Include in the description:</p> <ul style="list-style-type: none"> information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and 	

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	<p>caseworkers, or contracted parties) regarding changes to clinical and financial eligibility standards;</p> <ul style="list-style-type: none"> • types of media to be used; • specific geographical areas to be targeted for the Cash & Counseling Pilot and Adult Family Care program including the schedules for the public and participant information campaigns associated with the launching and continued program publicity; • locations where such information will be disseminated; • staff training schedules, schedules for State forums or seminars to educate the public; • training materials for intake and eligibility staff regarding changes in determining eligibility for demonstration groups that include but is not limited to changes in resource limits; • training materials, curriculum, and training schedule for State staff, case management agencies and Area Agencies on Aging regarding recruiting, identifying, and enrolling individuals, with special consideration to individuals who may qualify for the Moderate and High Need groups; • policies and procedures regarding ongoing training for current and new staff following the initiation of the program; • the availability of bilingual materials/interpretation services and services for individuals with special needs; • training of consumers, advocates and the members of the public on the concepts of the demonstration. <p>h. Notification to Program Participants. A plan that includes a timeline for notifying demonstration participants, including current eligibles receiving services through 1915(c) programs and nursing facility services, regarding eligibility changes to be implemented under the Long-Term Care Plan demonstration, including, but not limited to, their enrollment into a Section 1115 research and demonstration program.</p> <p>i. Eligibility/Enrollment. A description of the population of individuals eligible for the demonstration (and eligibility exclusions), including plans for population phase-in and 1915(c) program termination. Describe the processes for the following and include the organization responsible for each of the processes:</p> <ul style="list-style-type: none"> • determining eligibility including methods for applying income and resource rules for the categorically and medically needy with limits up to \$10,000, for 	

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	<p>individuals who are single and own their own home, and who select home-based services in lieu of institutional services or other residential care services;</p> <ul style="list-style-type: none"> • phasing-in changes in resource limits over the course of the demonstration and parameters for determining when the limits would increase, e.g., from \$2,000 to \$3,000, from \$3,000 to \$5,000 and from \$5,000 to \$10,000; • determining income and resource disregards for the Moderate Need, expansion population; • determining the clinical eligibility of individuals applying for services in the Moderate Need Group; • determining participants' and applicants' level of care including assessment instruments, policies, and procedures; • including mental status information in developing and carrying out service/treatment plans; • conducting intake, assessment, enrollment, and disenrollment; • conducting annual re-determinations of eligibility; • determining the existence and scope of a demonstration applicant's existing third party liability; • implementing consumer-directed services including the number of participants to be served, service area, and expansion projections; and • allocating a cash allotment to participants for self-directing services should this benefit prove feasible as a result of a pilot-program. <p>j. Enrollment Limit. Description of the enrollment limit and any process for revising the limit. Detailed description of how a waiting list will operate. Include any pertinent documentation or instructions for the waiting list as an attachment to the Protocol document. Include how individuals are selected from the waiting list to enter the program, how the list is maintained, the periodicity for assessing the changing needs of individuals on the waiting list, how the potential participants and applicants will be informed of their placement and standing on the list, how often they will be informed of their standing, and how the intake workers will be able to access and verify an individual's standing on the waiting list.</p> <p>k. Restricting Providers. A description of the process for selecting providers of nursing facility services and allocating nursing facility beds. Describe how the process and criteria used to select providers of nursing facility services and to</p>	

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	<p>allocate Medicaid- reimbursed, nursing facility beds is consistent with the requirements of section 1923 and is consistent with access, quality, and efficient and economic provision of care and services. Provide a timeline for implementing the selection process including pre- and post-implementation activities.</p> <p>I. Benefits. A complete description of Medicaid services covered under the demonstration which includes general service categories and the specific services included therein.</p> <ul style="list-style-type: none"> • Description of the amount, duration and scope of services for which each demonstration group will be eligible. Describe any interface with services provided through the State’s Older American Act funds, Community Rehabilitation and Treatment (CRT), PACE Vermont, grant or State-only funds. • Describe the services for which caregiver spouses or parents will be compensated and the mechanism for doing so. Include the criteria for determining who would receive services from caregiver spouses or parents. • Descriptions of the person-centered planning process used in the developing of the plan of care and the individual budget; methodology for establishing the budget for plans of care; how purchasing plans are developed; procedures and mechanisms to be used to review and adjust payments for plans of care; services which will be cashed out; and, procedures for amending the description of services. <p>m. Quality. Description of an overall quality assurance monitoring plan that includes but is not limited to the following:</p> <ul style="list-style-type: none"> • quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; • roles and responsibilities of agencies charged with implementing the quality assurance monitoring plan; • the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately; • the system the State will operate by which it receives, reviews and acts upon critical events or incidents and communicates with licensing and surveying entities, with a description of the critical events or incidents; • supervision of case management staff related to monitoring participant health 	

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	<p>and welfare;</p> <ul style="list-style-type: none"> • quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; • plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports; • procedures for assuring quality of care and participant safeguards; • procedures for insuring against duplication of payment between the demonstration; fee for service; Home and Community-Based Services waiver programs; the Vermont Health Access Plan 1115 Demonstration; PACE Vermont, Older Americans Act Programs; grant programs; including fraud control provisions and monitoring; • description of the State’s Utilization Review (UR) process – nursing homes or other designated entity – to ensure objectivity/control of conflict of interest; and, • plans for monitoring the administering of the Independent Living Assessment and procedures for addressing inconsistencies in administration, should these occur. <p>n. Self-Directed Supports: Education, Counseling, Fiscal Intermediary and Support Services. Descriptions of the following topics:</p> <ul style="list-style-type: none"> • the State’s relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal/employer agent services; • the procurement mechanism, standards, scope of work and payment process for the fiscal/employer agent; • procedures for ensuring sufficient availability of fiscal/employer agent services for participants who do not pass the mandatory test on employer responsibilities; • procedures for mandatory testing of participants related to fiscal and legal responsibilities and training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities; and, • the procedures that will govern how criminal background checks will be conducted on potential providers and how participants will be informed of the results of the criminal background checks. <p>o. Participant Protections for Self-Direction: A description of the State procedures</p>	

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	<p>and processes to assure that participant protections are in place. The description will include the following:</p> <ul style="list-style-type: none"> • procedures to assure that families have the requisite information and/or tools to direct and manage their care, including but not limited to employer agent services such as training in managing the caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment and taxation; • provisions for emergency back up and emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place; • procedures for how the State will work with individuals in the Cash and Counseling option who expend their individualized budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available; and, • procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination for Cash and Counseling participants. <p>p. Financial Incentives. Plan for encouraging individuals to plan for their future long-term care needs via financial incentives for purchasing long-term care insurance. Description of the activities and timeline for accomplishing this objective.</p> <p>q. Evaluation Design. A description of the State's evaluation design and a timeframe for implementing the design. The description will include the following (Attachment D provides an Evaluation Framework for submitting the Evaluation Design):</p> <ul style="list-style-type: none"> • discussion of the demonstration hypotheses that will be tested; • outcome measures that will be included to evaluate the impact of the demonstration; • financial impact data, including the number of people affected, the dollar value of services and other pertinent data. • description of data to be utilized; • description of methods of data collection; • how the effects of the demonstration will be isolated from those of other 	

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	initiatives occurring in the State; <ul style="list-style-type: none"> • any other information pertinent to the State’s evaluative or formative research via the demonstration operations; and • plans to include interim evaluation findings in the quarterly and annual progress reports. 	
Attachment A. General Financial Requirements	<p>1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).</p>	<p>The State is compliant.</p>
	<p>2.a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. Applicable rebates and expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which payments were made). For monitoring purposes, cost settlements will be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.</p>	<p>Cost settlements are not reported under the Choices for Care Demonstration.</p>
	<p>2.b. For each demonstration year five separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER reports will be submitted reporting expenditures subject to the budget neutrality cap. On the first form report the expenditures for the Highest Need Group. On the second form report the expenditures for the High Need Group. On the third form, report expenditures for the Moderate Need Group. On the fourth form, report expenditures for demonstration eligibles also receiving CRT services under the VHAP 1115. On the fifth form, report Medicaid expenditures for PACE participants. All expenditures subject to the budget neutrality ceiling for</p>	<p>The State is compliant.</p>

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	<p>demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2. c.). The Long-Term Care Plan Medicaid eligibility groups (MEGs), for reporting purposes, include the following names: Highest Need Group, High Need Group, Moderate Need Group, CRT Group, and PACE Group.</p>	
	<p>2.c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of demonstration eligibles. CRT for participants with severe, persistent mental illness would continue to be included in the Vermont Health Access Plan 1115 demonstration and excluded from the Long-Term Care Plan 1115 demonstration. Services for the expansion group include case management, homemaker, adult day services and additional services as identified over the lifetime of the demonstration.</p> <p>All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and will be reported on Form CMS 64.9 WAIVER and/or 64.9P WAIVER. The demonstration eligibles include the aged (age 65 years and older) and adults with physical disabilities (age 18 and through 64) who are in need of long-term care services (nursing facility, home and community-based services, PACE) or at risk of requiring nursing facility services. Services subject to budget neutrality would include State Plan services, home and community-based services, including Enhanced Residential Care, as currently defined under Vermont's 1915(c) programs, PACE and nursing facility services.</p>	<p>The State is compliant.</p>
	<p>2.d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, such as additional staff, equipment for those staff, space costs associated with those staff and contracts for technical assistance All administrative costs will be identified on the Forms CMS-64.10 WAIVER and/or 64.10P WAIVER.</p>	<p>The State is compliant.</p>
	<p>2.e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) will be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) will be made within 2 years after the conclusion or termination of the demonstration. During the latter 2 year period, the State will continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form</p>	<p>The State is compliant.</p>

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	CMS-64 in order to properly account for these expenditures in determining budget neutrality.	
	2.f. The procedures related to this reporting process, report contents, and frequency will be discussed by the State in the Operational Protocol, to be included in the description in item 19.b. of Section V of this document.	The State is compliant.
	3.a. For the purpose of monitoring the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 10 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section V.).	The State is compliant.
	3.b. The term, “eligible member/months” refers to the number of months in which persons are eligible to receive demonstration or State Plan services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.	The State is compliant.
	3.c. The term “demonstration eligibles” refers to adults (age 65 years and older) and adults with physical disabilities (age 18 and older) who meet criteria for long-term care services in the community or in a nursing facility or who are at-risk of needing long-term care services. Specifically, demonstration eligibles include 1) participants in the 1915(c) Home and Community-Based Services Program for the Elderly and Disabled and the 1915(c) Enhanced Residential Care Program; 2) participants receiving long-term care services in a nursing facility; 3) participants meeting the demonstration’s financial eligibility and long-term care clinical eligibility criteria for the Highest, High, and Moderate Need Groups; 4) participants meeting demonstration financial and clinical eligibility criteria and receiving CRT services under the VHAP 1115; and, 5) PACE participants.	Exceptions are made for a small number of people under the age of 18 who need nursing home services, which are only available through Choices for Care.
	4. The standard Medicaid funding process will be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/Federal share) subject to the budget neutrality cap must be	The State is compliant.

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	<p>separately reported by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2.c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State will submit the Form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.</p>	
	<p>5. The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:</p> <ul style="list-style-type: none"> a) Administrative costs, including those associated with the administration of the demonstration. b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan. c) Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration. 	The State is compliant.
	<p>6. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.</p>	The State is compliant.
<p>Attachment B. Monitoring Budget Neutrality</p>	<p>The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Special Terms and Conditions specify the aggregate financial cap on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in 2.c. of attachment A of this document. If the demonstration is delayed beyond September 1, 2005, the financial cap will be adjusted using the same trending as used to calculate the figure below. The budget neutrality cap will be for the Federal share of the total computable cost of \$1,235,978,987 for the 5-year demonstration. The cap places the State at risk for enrollment and for Per Participant Per Month (PPPM) cost trends.</p>	The State is compliant.

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	<p>Impermissible DSH, Taxes or Donations: The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.</p>	The State is compliant.
	<p>Changes Resulting from Implementation of the Medicare Modernization Act (MMA): The State and CMS will develop a modified budget limit to respond to the implementation of the MMA. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.</p>	The State is compliant.
	<p>How the Limit will be Applied: The limit calculated above will apply to actual expenditures for demonstration, as reported by the State under Attachment A. If at the end of the demonstration Period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.</p>	The State is compliant.
	<p>Expenditure Review: The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.</p>	The State has not exceeded its annual limitations. Please refer to Section 6 on Budget Neutrality.

Subject Area	Special Terms and Conditions				Compliance/Status
	Year	Cumulative Target (Total Computable Cost)	Cumulative Target Definition	Percentage	
	Year 1	\$214,281,572	Year 1 budget estimate plus	8 percent	
	Year 2	\$431,229,252	Years 1 and 2 combined budget estimate plus	3 percent	
	Year 3	\$669,819,392	Years 1 through 3 combined budget estimate plus	1 percent	
	Year 4	\$939,308,680	Years 1 through 4 combined budget estimate plus	0.5 percent	
	Year 5	\$1,235,978,987	Years 1 through 5 combined budget estimate plus	0 percent	
Attachment C. Reporting Items	Monthly conference calls: <ul style="list-style-type: none"> Timeframe for Item: Prior to demonstration implementation and Post-implementation Frequency of Item: Monthly progress calls with CMS and the State 				The State is compliant.
	Operational Protocol: <ul style="list-style-type: none"> Timeframe for Item: Due to CMS 30 days after program approval, CMS comments 30 days after receipt, and State completion/CMS approval thereafter Frequency of Item: One Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS 				The State is compliant.
	Quarterly/Annual Progress Reports: <ul style="list-style-type: none"> Timeframe for Item: Due to CMS 60 days after the end of a quarter Frequency of Item: One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report 				The State is compliant.

Subject Area	Special Terms and Conditions	Compliance/Status
	<p>Final Report:</p> <ul style="list-style-type: none"> • Timeframe for Item: Due to CMS 180 days after the end of the demonstration • Frequency of Item: One final report 	<p>The Choices for Care Demonstration is in progress. The State secured a contract with the University of Massachusetts Center for Health Policy and Research (CHPR) for an initial three-year contract period to perform an independent evaluation, including policy briefs, consumer survey analysis, and overall evaluation report.</p> <p>DAIL and CHPR have developed a final evaluation plan. This plan is available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-plan</p> <p>The State issued a Request for Proposal to obtain an independent evaluator through the Demonstration’s extension period, and again selected the University of Massachusetts through this process.</p>
<p>Attachment D. Evaluation Framework</p>	<p>Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations and other innovations that would not otherwise be part of Medicaid programs. The CMS encourages States with demonstration programs to conduct or arrange for evaluations of the design, implementation and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.</p> <p>The CMS believes that all parties to demonstrations; States, Federal government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations – these would include, but not be limited to: 1) studies that document the design, development, implementation and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.</p>	<p>The Choices for Care Demonstration is in progress. The State secured a contract with the University of Massachusetts Center for Health Policy and Research (CHPR) for an initial three-year contract period to perform an independent evaluation, including policy briefs, consumer survey analysis, and overall evaluation report.</p> <p>DAIL and CHPR have developed a final evaluation plan. This plan is available online at: http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-plan</p> <p>The State issued a Request for Proposal to obtain an independent evaluator through the Demonstration’s extension period, and again selected the University of Massachusetts through</p>

Subject Area	Special Terms and Conditions	Compliance/Status
	<p>Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes and regulations.</p> <p>States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.</p> <p>The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.</p> <ul style="list-style-type: none"> • Evaluation Plan Development - Describe how plan was or will be developed and maintained: <ul style="list-style-type: none"> ○ Use of experts through technical contracts or advisory bodies; ○ Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients); ○ Selection of existing indicators or development of innovative indicators; ○ Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations; ○ Types of data collection and tools that will be used – for instance participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and whether the data collection instruments will be existing or newly developed tools; ○ Incorporation of results through QA/QI activities into improving health service delivery; and ○ Plans for implementation and consideration of ongoing refinement to the evaluation plan. • Study Questions – Discuss: <ul style="list-style-type: none"> ○ Hypothesis or research questions to be investigated; ○ Goals, such as: <ul style="list-style-type: none"> ▪ Increase Access 	<p>this process.</p>

Subject Area	Special Terms and Conditions	Compliance/Status
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Cost Effectiveness ▪ Improve Care Coordination ▪ Increase Family Satisfaction and Stability ○ Outcome Measures, Indicators, and Data Sources • Control Group and/or Sample Selection Discussion: <ul style="list-style-type: none"> ○ The type of research design(s) to be included - <ul style="list-style-type: none"> ▪ Pre/Post Methodology ▪ Quasi-Experimental ▪ Experimental ○ Plans for Base-line Measures and Documentation – time period, outcome measures, indicators and data sources that were used or will be used • Data Collection Methods – Discuss the use of data sources such as: <ul style="list-style-type: none"> ○ Enrollment and outreach records; ○ Medicaid claims data; ○ Vital statistics data; ○ Provide record reviews; ○ School record reviews; and ○ Existing or custom surveys • Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss: <ul style="list-style-type: none"> ○ How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations; ○ How findings will be incorporated into outreach, enrollment and education activities; ○ How findings will be incorporated into provider relations such as provider standards, retention, recruitment and education; and ○ How findings will be incorporated into grievance and appeal proceedings. • Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention. 	

Section 4: Waiver and Expenditure Authorities

At this time no additional waivers and expenditure authorities are being requested in the extension of the Choices for Care Demonstration. The following is a list of the Waiver and Expenditure authorities approved under the initial waiver application. Vermont requests continuation of these waiver and expenditure authorities.

Waivers

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), waivers of the following provisions of the Act (and its regulations) were granted through the period of five years to carry out the demonstration, consistent with the accompanying special terms and conditions:

1. **Statewideness/Uniformity (1902(a)(1))** – To restrict services to certain geographical areas of the State; to allow the program to be phased-in to new areas during the demonstration and to allow program elements to be phased-in during the demonstration.
2. **Reasonable Promptness (1902(a)(8))** – To allow the State to maintain a waiting list for high and moderate need individuals applying for long-term care services. To allow the State to required applicants for long-term care services to complete a person-centered assessment and options counseling program.
3. **Comparability (1902(a)(10)(B))** – To allow the State to provide nursing facility and home and community-based services based on relative need as part of the person-centered assessment and options counseling process for new applicants for such services; to permit the provision of services under the demonstration that will not otherwise be available under the State Plan; to limit the amount, duration and services to those included in the participants' approved care plan.
4. **Freedom of Choice (1902(a)(23))** – To enable the State to restrict freedom of choice of nursing facility providers.
5. **Direct Payments to Providers (1902(a)(32))** – To permit payments for incidental purchases to be made directly to beneficiaries or their representatives.

Expenditures

Under the authority of section 1115(a)(2) of the act, expenditures made by the State under the Long Term Care Plan demonstration are regarded as expenditures for a period of five years under the State's Title XIX plan:

1. Expenditures for home and community-based services for elderly and disabled adults, with income up to 300 percent of Supplemental Security Income (SSI) payment level, who do not meet the demonstration's clinical criteria for long-term care services, but are at risk of institutionalization.
2. Expenditures for home- and community-based services for participants who are single and own and reside in their own homes, and with resources that exceed current limits who select home-based care rather than nursing facility care, to allow them to retain resources to remain in the community.
3. Expenditures for personal care services provided by participants' spouses.
4. Expenditures for incidental purchases paid out of cash allotments to participants who are self-directing their services prior to service delivery.

The following will not be applicable to individuals who are not otherwise eligible under the Medicaid State Plan:

Cost-sharing and Premiums – 1916

Retroactive Eligibility – 1902(a)(34)

Section 5: Quality and Program Evaluation

The Choices for Care Special Terms and Conditions require quality assurance and quality improvement (QA/QI) activities and evaluation of the project. Through ongoing program monitoring and evaluation, Vermont assures CMS that it remains in substantial compliance with the Choices for Care STCs. Vermont's comprehensive quality management system will continue to expand and identify any systematic challenges facing Choices for Care and appropriate improvements. The following highlights Vermont's QA/QI and evaluative initiatives.

Quality

When Choices for Care was initially implemented, quality management activities were performed under a broad Quality Management Plan that had been developed under a CMS Quality Assurance/Quality Improvement Real Choices Grant, following the CMS Quality Framework. More recently, the Division of Disability and Aging Services (DDAS) restructured and incorporated staff from the Quality Management Unit into various other units within DDAS. A workgroup was formed with representation from the State Unit on Aging and the Adult Services Unit to identify new methods of quality management for Choices for Care.

The Case Management Quality Workgroup is developing a plan to provide adequate quality assurance and improvement activities for Choices for Care and Older Americans Act case management services within the available but limited state staff resources. This plan will focus on Case Management Agency Certification, Case Manager Training Curriculum, the development of a DDAS Complaint /Incident System, and a revised process for reviewing the quality of services through the "lens" of case management. Other ongoing quality management activities include:

- *Case Management Services* – Participants receive case management services to assist them in gaining access to needed medical, social, and educational services. Case Management Services provide participants with a detailed needs assessment and assist individuals in creating a comprehensive plan of care. In addition, Case Management Services assists DAIL by providing ongoing assessment and monitoring of the quality, effectiveness, and efficiency of Choices for Care services.
- *Consumer Satisfaction and Feedback* – Choices for Care's Quality Management Plan focuses on participant outcomes such as quality of life and person centeredness. In addition to obtaining consumer feedback on an ongoing basis, DAIL contracted with Macro International Inc. to conduct annual statewide surveys of individuals receiving services from DAIL-sponsored programs. The consumer satisfaction survey asked individuals about their experiences with Attendant Services, Homemaker Services, Choices for Care Personal Care Services, and Adult Day Services. As noted earlier, Vermont's consumers indicated overwhelming satisfaction with, and approval of, the programs in which they participate.

- *Oversight of Providers* – Agency providers are subject to DAIL oversight. DAIL conducts provider monitoring and licensing activities through the DDAS and the Division of Licensing and Protection (DLP). Procedures include observation of resident care processes and environment; resident, family members, and staff interviews; review of clinical records; provider record reviews; and physical site-inspections. Safeguards also are in place to help ensure the quality of services rendered by independent providers participating in the consumer-directed surrogate-directed care or Flexible Options. For example, case managers work with members and/or their surrogates as they execute their employer responsibilities.
- *Partnership with the Long-Term Care Ombudsman* – Complaints from Choices for Care consumers are brought to the Ombudsman, where consumers receive support in resolving their complaints. DDAS works closely and meets on a quarterly basis with the Ombudsman to discuss findings, quality issues, and program improvement.

In 2007, DAIL contracted with the University of Massachusetts Medical School’s Center for Health Policy and Research (CHPR) to provide evaluative services for the Choices for Care project. As a part of ongoing evaluation activities, CHPR publishes a series of Technical Assistance and Policy Briefs. In April 2009, CHPR issued a Quality Oversight policy brief discussing the current quality initiatives being undertaken by Choices for Care and proposed recommendations to enhance quality oversight of services.

CHPR recommended that DAIL develop a standing quality workgroup to coordinate quality improvement activities across programs; modify licensing standards to encompass consumer-centered principles; analyze licensing data of providers against desired outcomes; maximize desk reviews of providers’ quality assurance data/reports; conduct comprehensive reviews of case management agencies; collect community residents’ feedback using a large scale survey; and use consumer, provider, and stakeholder interviews to help identify solutions to systemic issues. As previously noted, DAIL has convened a workgroup to identify new methods of quality management for Choices for Care.

Program Evaluation

Choices for Care’s evaluation plan is guided by nine desired outcomes consisting of seven short-term and two long-term outcomes. The complete evaluation logic and plan are provided in Appendix C (“Vermont Choices for Care: Evaluation Plan Logic Model”) and Appendix D (“Vermont Choices for Care: Final Evaluation Plan”). To measure the degree to which these desired outcomes are achieved, DAIL and CHPR proposed at least one evaluation question for each outcome. The questions are specified in a way to set forth an actionable and feasible evaluation:

Short-Term Desired Outcomes

1. **Information Dissemination** – Choices for Care participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with participant’s expressed preferences and needs:
 - To what extent did participants receive information to make choices and express preferences regarding services and settings?
2. **Access** – Choices for Care participants have timely access to long-term care supports in the setting of their choice:
 - Are new Choices for Care participants or nursing home residents who seek discharge able to receive Choices for Care services in a timely manner?
 - To what extent are Choices for Care participants receiving the types and amounts of supports consistent with their currently assessed needs?
3. **Effectiveness** – Participants receive effective home and community-based services to enable participants to live longer in the community:
 - Is Choices for Care increasing in its ability to serve participants in all Choices for Care levels of need in the community?
 - To what extent are participants’ long-term care supports coordinated with each other for the purpose of providing effective care?
 - To what extent did Medicaid nursing facility residents’ acuity, as measured by physical and cognitive performance, change over the Demonstration period?
4. **Experience with Care** – Participants have positive experiences with the types, scope, and amount of Choices for Care services:
 - To what extent do Choices for Care participants report having positive experiences with the types, amount, and scope of Choices for Care services?
5. **Quality of Life** – Participants’ report that their quality of life improves:
 - To what extent did Choices for Care participants’ reported quality of life improve over the Demonstration period?
6. **Impact of Waiting List** – Choices for Care applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g., nursing home, enhanced residential care, home care):
 - To what extent does the implementation of a waiting list for the high needs group in Choices for Care have different impact on applicants waiting to access home and community-based services versus nursing facility services?
7. **Budget Neutrality** – Medicaid cost of serving Choices for Care participants is equal to or less than Medicaid and home and community-based services funding:

- Were the average annual costs of serving Choices for Care participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?

Long-Term Desired Outcomes

8. **Public Awareness** – Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and individuals have enough information to make decisions regarding long-term care:
 - To what extent are Vermont residents who are hospitalized aware of long-term care setting options at the time of discharge?
 - To what extent are Vermont residents who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?
9. **Health Outcomes** – Choices for Care participants’ medical needs are addressed to reduce preventable hospitalizations and long-term care needs are effectively addressed:
 - To what extent are Choices for Care participants’ long-term care needs being effectively addressed?
 - To what extent are participants’ medical needs addressed to reduce preventable hospitalizations?

The evaluation plan consists of two major components: the evaluation of process and the evaluation of outcomes. DAIL and CHPR identified, when possible, both process and outcome indicators for each evaluation question. These indicators serve as discrete markers for DAIL to immediately monitor and discern whether or the degree to which desirable changes are occurring.

Given the comprehensive scope of the evaluation plan, DAIL and CHPR are taking a phased approach to the analysis of process and outcome indicators and evaluation questions. To date, CHPR has conducted a number of analyses evaluating Choices for Care policies and procedures as well as progress in meeting desired program outcomes:

- Stakeholder and Consumer Focus Group and Interviews in Year 2 (2008)
- Eligibility Policy Brief (2008)
- Enrollment and Waiting List Policy Brief (2008)
- Quality Management Policy Brief (2009)
- Quantitative Data Report for Demonstration years 1 and 2 (2009)
- 2008 Choices for Care Outcomes “At-A-Glance” (2009)
- Evaluation of Years 1-3 (2009)

The findings of the independent evaluation are described in detail in Appendix E (“Vermont Choices for Care: Evaluation of Years 1-3”). Exhibit 5.1 below highlights some of the major evaluation findings to date.

Exhibit 5.1 – Major Evaluation Findings

Outcomes	Major Findings
<i>Information Dissemination</i>	<ul style="list-style-type: none"> • Individuals are enrolled and made aware of service options through a case manager or a state long-term care clinical coordinator • Stakeholders are knowledgeable that care is available in the community and nursing facilities, but less so with new options • DAIL initiated a major educational event to promote awareness among providers
<i>Access</i>	<ul style="list-style-type: none"> • Financial eligibility determination was found to be less timely than clinical eligibility determination • Choices for Care implemented a “60-day closure” process to help speed the review process for all pending applications • Quantitative analysis and participant surveys results indicated timeliness of this process improved
<i>Effectiveness</i>	<ul style="list-style-type: none"> • Nursing facilities continued to be the most frequent setting for enrollees, followed by HCBS and ERC settings • Enrollment trend has increased in community settings and decreased in nursing facilities
<i>Experience of Care</i>	<ul style="list-style-type: none"> • A very high percentage of Choices for Care community-dwelling participants reported high satisfaction with the courtesy of their caregivers • Moderate Needs Group participants, with access to more limited service hours, had less positive experiences, compared to Highest and High Needs participants
<i>Quality of Life</i>	<ul style="list-style-type: none"> • Choices for Care participants generally rated higher levels of satisfaction with services than with quality of life-related indicators (e.g., how they “spent their free time” and “social connections”) • Stakeholders reported that more companion services and non-medical transportation were desirable
<i>Applicants List (Waiting List) Impact</i>	<ul style="list-style-type: none"> • During CHPR’s three-year evaluation period, the average monthly number of High Need Group individuals on the applicants list progressively declined • Moderate Need Group providers (homemakers and adult day providers) also maintained waiting lists, with more individuals waiting for homemaker services than for adult day care services
<i>Budget Neutrality</i>	<ul style="list-style-type: none"> • Choices for Care actual spending was well below spending projections to CMS during each federal fiscal year, even though state appropriations for Choices for Care as a percentage of the CMS annual projection climbed steadily • While each year’s spending stayed within one percent of state appropriations, actual spending exceeded state appropriations during the second and third years of the Demonstration

Vermont will continue to follow the evaluation plan during the extension period. As required by Vermont contracting rules, DAIL recently issued two requests for proposals for consumer satisfaction surveys and continued independent evaluation services. The survey contractor will

compare current consumer perceptions of long term care services with previous consumer perceptions of long term care services, including Choices for Care home and community based services. In addition, the contractor will compare perceptions of quality of life between users of long term care services and the general Vermont population. The 2010 survey will be conducted between September 1, 2010 and November 30, 2010.

DAIL issued a request for proposal to obtain a contractor to complete the independent evaluation through an additional three years, and again selected the University of Massachusetts through this process. The University of Massachusetts will collaborate with DAIL in continuing the evaluation plan including a policy brief describing how hospital discharge planning processes currently influence Vermont consumer choice and use of different long term care settings; receive survey results from the survey contractor and complete multivariate analyses across datasets; and develop an evaluation report, including findings and recommendations.

Section 6: Compliance with and Projected Budget Neutrality Status

This section provides historical and projected expenditure and caseload estimates for the Choices for Care Demonstration for the initial five-year period (October 2005 – September 2010) as well as the five-year renewal period (October 2010 – September 2015). The Demonstration is subject to a limit on the amount of federal Medicaid funding for the selected Medicaid expenditures during the waiver demonstration period. To date, implementation of Choices for Care has demonstrated cost savings for the provision of long-term care services. Vermont anticipates savings to continue during the renewal period.

The budget neutrality estimates are presented in a series of tables as follows. Tables 6.1 through 6.6 represent the calculations underlying the current waiver limit and actual program performance. Tables 6.7 through 6.9 present the projected program expenditures for the extension period.

Table 6.1 below provides the projected expenditures without implementation of the waiver for eligibility groups by type of long-term care setting: nursing facility, HCBS, and enhanced residential care. Expenditures with and without adjustments made by the Medicare Modernization Act (MMA) also are presented below. The trend rates are based on the current rates established under the Choices for Care waiver.

Table 6.1 – Projected Expenditures Without Waiver, Initial Five-Year Period (Oct '05 – Sep '10)

Eligibility Group	TREND RATE	INITIAL FIVE-YEAR PERIOD					Five-Year Total
		DY 01	DY 02	DY 03	DY 04	DY 05	
Pop. 1 NF							
Caseload	3.48%	2,348	2,430	2,514	2,602	2,692	
Total Cost Per Eligible	7.28%	\$ 59,180	\$ 63,488	\$ 68,110	\$ 73,069	\$ 78,388	
Total Expenditure		\$ 138,958,676	\$ 154,262,673	\$ 171,252,152	\$ 190,112,741	\$ 211,050,511	\$ 865,636,753
Pop. 2 HCBS							
Caseload	3.48%	1,071	1,108	1,146	1,186	1,228	
Total Cost Per Eligible	7.28%	\$ 40,406	\$ 43,347	\$ 46,503	\$ 49,888	\$ 53,520	
Total Expenditure		\$ 43,260,502	\$ 48,024,929	\$ 53,314,080	\$ 59,185,743	\$ 65,704,073	\$ 269,489,327
Pop. 3 ERC							
Caseload	3.48%	159	164	170	176	182	
Total Cost Per Eligible	7.28%	\$ 28,981	\$ 31,091	\$ 33,354	\$ 35,783	\$ 38,387	
Total Expenditure		\$ 4,599,244	\$ 5,105,774	\$ 5,668,091	\$ 6,292,337	\$ 6,985,334	\$ 28,650,781
Expenditures w/o Yr 1 MMA Adj.		\$ 186,818,422					
Year 1 Adjustment: Pre-MMA (Jan '06)		\$ 2,897,635					
Total Plan Expenditure		\$ 189,716,057	\$ 207,393,377	\$ 230,234,323	\$ 255,590,821	\$ 283,739,918	\$ 1,166,674,496

Table 6.2 on the following page presents the average annual growth in caseload for the waiver-participating eligibility groups: Highest Need, High Need, Moderate Need, PACE, and Community Rehabilitation and Treatment (CRT). As indicated by the presented data, there was

some fluctuation in reported member months, particularly during the early stages of the project. After implementation of the Demonstration, the State reassessed participants for the Highest and High Need Group criteria. The State subsequently transitioned individuals from the Highest Need to High Need Group as appropriate. These fluctuations represent only a reporting issue and do not impact expenditures in the aggregate. A uniform methodology was applied to calculate member months.

Table 6.2 – Actual Caseload, Initial Five-Year Period (Member Months) (Oct '05 – Sep '10)

Eligibility Group	DY 01	DY 02	DY 03	DY 04	DY 05 (est.)	Average Annual Growth (1-4)
Highest	42,414	42,136	40,821	40,879	40,380	-1.22%
High*	757	3,235	6,626	5,534	6,001	94.08%
Moderate	4,584	6,693	11,493	13,435	14,568	43.11%
PACE	0	45	360	722	783	
CRT	1,134	1,352	1,730	1,758	1,906	15.74%
Total	48,889	53,461	61,030	62,328	63,637	8.43%

* Estimate for Year 1.

Actual expenditures for the initial five-year period of the Demonstration are provided below in Table 6.3. The expenditures reported below do not include third party liability (TPL) or estate recovery, which are both reported separately from the Demonstration. The expenditures reported for Year 5 are an estimate as the Demonstration is currently in its fifth year of operation. Average trend rates are presented for Years 1 through 4.

Table 6.3 – Actual Expenditures, Initial Five-Year Period (Oct '05 – Sep '10)

Eligibility Group	DY 01	DY 02	DY 03	DY 04	DY 05 (est.)	Average Annual Growth (1-4)
Highest	\$ 163,975,136	\$ 165,326,225	\$ 166,053,241	\$ 164,629,436	\$ 169,464,557	0.13%
High	\$ 534,067	\$ 6,066,383	\$ 17,701,241	\$ 17,512,873	\$ 19,065,618	220.08%
Moderate	\$ 1,234,143	\$ 1,594,289	\$ 3,035,441	\$ 4,000,240	\$ 4,177,418	47.99%
PACE	\$ -	\$ 167,824	\$ 1,359,544	\$ 2,980,450	\$ 3,112,460	
CRT	\$ 4,230,692	\$ 5,274,676	\$ 5,403,024	\$ 4,451,565	\$ 4,527,723	1.71%
Total	\$ 169,974,038	\$ 178,429,397	\$ 193,552,491	\$ 193,574,564	\$ 200,347,775	4.43%

The actual program cost per member per month (PMPM) over the initial five-year period is presented in Table 6.4. Average annual trend rates are presented for Years 1 through 4.

Table 6.4 – Actual Cost Per Member Per Month, Initial Five-Year Period (Oct '05 – Sep '10)

Eligibility Group	DY 01	DY 02	DY 03	DY 04	DY 05 (est.)	Average Annual Growth (1-4)
Highest	\$ 3,866	\$ 3,924	\$ 4,068	\$ 4,027	\$ 4,197	1.37%
High	\$ 706	\$ 1,875	\$ 2,671	\$ 3,165	\$ 3,177	64.92%
Moderate	\$ 269	\$ 238	\$ 264	\$ 298	\$ 287	3.41%
PACE	\$ -	\$ 3,729	\$ 3,777	\$ 4,128	\$ 3,976	
CRT	\$ 3,731	\$ 3,901	\$ 3,123	\$ 2,532	\$ 2,375	-12.12%
Total	\$ 3,477	\$ 3,338	\$ 3,171	\$ 3,106	\$ 3,148	-3.69%

Table 6.5 below provides the aggregate expenditures by service category during the initial five-year waiver period.

Table 6.5 – Aggregate Expenditures by Service Category, Initial Five-Year Period (Oct '05 – Sep '10)

Category of Service	DY 01	DY 02	DY 03	DY 04	DY 05 (est.)	Average Annual Growth (1-4)
Nursing Facility	\$ 105,928,659	\$ 111,387,908	\$ 114,232,636	\$ 115,213,286	\$ 119,244,621	2.84%
Home and Community Based Services	\$ 37,745,313	\$ 45,002,859	\$ 52,184,111	\$ 50,462,195	\$ 52,227,877	10.16%
Other Medicaid Services	\$ 26,300,067	\$ 22,038,630	\$ 27,135,744	\$ 27,899,083	\$ 28,875,277	1.99%
Total	\$ 169,974,038	\$ 178,429,397	\$ 193,552,491	\$ 193,574,564	\$ 200,347,775	4.43%

Table 6.6 provides a summary of Demonstration spending relative to the aggregate spending limit. In summary, Vermont estimates that the total program spending will fall below the limit and that aggregate waiver savings for the initial five-year period will be approximately \$231 million.

Table 6.6 – Summary of Expenditures With and Without Waiver, Initial Five-Year Period

(Oct '10 – Sep '15)

Expenditures	DY 01	DY 02	DY 03	DY 04	DY 05 (est.)	Five-Year Total
Aggregate Spending Limit	\$ 189,716,057	\$ 207,393,377	\$ 230,234,323	\$ 255,590,821	\$ 283,739,918	\$ 1,166,674,496
Program Expenditures	\$ 169,974,038	\$ 178,429,397	\$ 193,552,491	\$ 193,574,564	\$ 200,347,775	\$ 935,878,265
Surplus (Deficit)	\$ 19,742,019	\$ 28,963,980	\$ 36,681,832	\$ 62,016,257	\$ 83,392,143	\$ 230,796,231
Cumulative Surplus (Deficit)	\$ 19,742,019	\$ 48,705,999	\$ 85,387,831	\$ 147,404,089	\$ 230,796,231	
Cumulative Percentage Surplus (Deficit)	10.4%	12.3%	13.6%	16.7%	19.8%	

Table 6.7 presents the projected expenditures without the waiver for the five-year extension period. The projected expenditures without the waiver represent a continuation of the current baseline expenditures, using the same caseload and cost per eligible trend rates that were applied to the initial five-year projection.

Table 6.7 – Projected Expenditures Without Waiver (Oct '10 – Sep '15)

Eligibility Group	TREND RATE	FIVE-YEAR RENEWAL PERIOD					Five-Year Total
		DY 06	DY 07	DY 08	DY 09	DY 10	
Pop. 1 NF							
Caseload	3.48%	2,786	2,883	2,983	3,087	3,195	
Total Cost Per Eligible	7.28%	\$ 84,095	\$ 90,217	\$ 96,785	\$ 103,831	\$ 111,390	
Total Expenditure		\$ 234,294,230	\$ 260,097,859	\$ 288,743,331	\$ 320,543,627	\$ 355,846,200	\$ 1,459,525,247
Pop. 2 HCBS							
Caseload	3.48%	1,270	1,315	1,360	1,408	1,457	
Total Cost Per Eligible	7.28%	\$ 57,416	\$ 61,596	\$ 66,081	\$ 70,891	\$ 76,052	
Total Expenditure		\$ 72,940,288	\$ 80,973,453	\$ 89,891,338	\$ 99,791,380	\$ 110,781,748	\$ 454,378,208
Pop. 3 ERC							
Caseload	3.48%	188	195	202	209	216	
Total Cost Per Eligible	7.28%	\$ 41,182	\$ 44,180	\$ 47,396	\$ 50,847	\$ 54,549	
Total Expenditure		\$ 7,754,653	\$ 8,608,700	\$ 9,556,805	\$ 10,609,329	\$ 11,777,771	\$ 48,307,258
Total Plan Expenditure		\$ 314,989,171	\$ 349,680,012	\$ 388,191,474	\$ 430,944,337	\$ 478,405,719	\$ 1,962,210,713

Table 6.8 represents Vermont's estimate of projected program expenditures for all the Demonstration eligibility groups. The table includes the caseload and total cost per eligible trends.

Table 6.8 – Projected Expenditures With Waiver (Oct '10 – Sep '15)

Eligibility Group	TREND RATE	INITIAL FIVE-YEAR PERIOD					Five-Year Total
		DY 06	DY 07	DY 08	DY 09	DY 10	
Highest							
Caseload	3.48%	43,774	45,297	46,873	48,505	50,192	
Total Cost Per Eligible	7.28%	\$ 4,635	\$ 4,972	\$ 5,334	\$ 5,723	\$ 6,139	
Total Expenditure		\$ 202,888,700	\$ 225,233,531	\$ 250,039,274	\$ 277,576,960	\$ 308,147,465	\$ 1,263,885,931
High							
Caseload	3.48%	5,926	6,132	6,345	6,566	6,795	
Total Cost Per Eligible	7.28%	\$ 3,642	\$ 3,907	\$ 4,192	\$ 4,497	\$ 4,824	
Total Expenditure		\$ 21,582,799	\$ 23,959,787	\$ 26,598,561	\$ 29,527,952	\$ 32,779,967	\$ 134,449,065
Moderate							
Caseload	3.48%	14,386	14,887	15,405	15,941	16,496	
Total Cost Per Eligible	7.28%	\$ 343	\$ 368	\$ 394	\$ 423	\$ 454	
Total Expenditure		\$ 4,929,881	\$ 5,472,826	\$ 6,075,567	\$ 6,744,690	\$ 7,487,506	\$ 30,710,468
PACE							
Caseload	3.48%	773	800	828	857	886	
Total Cost Per Eligible	7.28%	\$ 4,751	\$ 5,097	\$ 5,468	\$ 5,866	\$ 6,293	
Total Expenditure		\$ 3,673,095	\$ 4,077,626	\$ 4,526,709	\$ 5,025,251	\$ 5,578,699	\$ 22,881,381
CRT							
Caseload	3.48%	1,882	1,948	2,016	2,086	2,159	
Total Cost Per Eligible	7.28%	\$ 2,914	\$ 3,126	\$ 3,354	\$ 3,598	\$ 3,860	
Total Expenditure		\$ 5,486,092	\$ 6,090,294	\$ 6,761,039	\$ 7,505,656	\$ 8,332,279	\$ 34,175,361
Total Caseload							
		66,742	69,064	71,468	73,955	76,528	
Total Plan Expenditure							
		\$ 238,560,568	\$ 264,834,064	\$ 294,001,150	\$ 326,380,508	\$ 362,325,916	\$ 1,486,102,206

Table 6.9 provides a summary of projected spending relative to the aggregate waiver limit. In summary, Vermont estimates that total program spending will fall below the limit and that aggregate waiver savings through the extension period will reach nearly \$480 million.

Table 6.9 – Summary of Expenditures With and Without Waiver, Projected (Oct '10 – Sep '15)

Expenditures	DY 06	DY 07	DY 08	DY 09	DY 10	Five-Year Total
Aggregate Spending Limit	\$ 314,989,171	\$ 349,680,012	\$ 388,191,474	\$ 430,944,337	\$ 478,405,719	\$ 1,962,210,713
Program Expenditures	\$ 238,560,568	\$ 264,834,064	\$ 294,001,150	\$ 326,380,508	\$ 362,325,916	\$ 1,486,102,206
Surplus (Deficit)	\$ 76,428,603	\$ 84,845,948	\$ 94,190,324	\$ 104,563,829	\$ 116,079,803	\$ 476,108,507
Cumulative Surplus (Deficit)	\$ 76,428,603	\$ 161,274,551	\$ 255,464,876	\$ 360,028,704	\$ 476,108,507	
Percentage Surplus (Deficit)	24.3%	24.3%	24.3%	24.3%	24.3%	

Section 7: Responses to CMS Standard Funding Questions

The following are responses to the Standard Funding Questions from CMS. Please note that there are no intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments under the Choices for Care Demonstration. However, Vermont has limited use of CPEs as part of the full complement of Medicaid program financing in the State. The responses and tables presented below are representative of the full complement of Medicaid financing in Vermont.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan.
 - a. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

Response – *Providers receive and retain 100 percent of Medicaid expenditures for State Plan covered services.*

- b. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?

Response – *Vermont has limited use of CPEs. Vermont's use of CPEs is described further in response to Question 2. Providers are not required to return any portion of payments.*

- c. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Response – *Providers are not required to return any portion of payments for State Plan covered services.*

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

- a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

Response – *The non-Federal share of all Medicaid payments are identified in the appropriations act as passed by the Vermont Legislature.*

- b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Response – *The non-Federal share of all Medicaid payments are identified in the appropriations act as passed by the Vermont Legislature. Vermont has limited use of CPEs, but funds are appropriated by Legislative reference.*

	<i>Department of Education</i>	<i>UVM/VCHIP</i>	<i>Local Schools</i>	<i>“Other” Designated Agencies</i>
<i>Origin of State Matching Funds (i.e., State/Local)</i>	<i>State</i>	<i>State and Other</i>	<i>State</i>	<i>State and Municipalities</i>
<i>Receiver of Appropriation</i>	<i>Department of Education</i>	<i>UVM</i>	<i>Local Schools</i>	<i>Local Schools</i>
<i>Executed Contract with the State Medicaid Agency (SMA)</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>

- c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Response – *Nearly all Vermont Medicaid payments are represented by the managed care capitation rates paid by the Single State Agency (AHS) to the public managed care entity (OHVA). The non-Federal share that is used as match for the capitation payments is identified by the Vermont Legislature.*

- d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Response – Vermont documents the CPEs as they are received as non-Federal match for the purposes of making the monthly capitation payment to the publicly-operated managed care entity. The table below presents the timing of certifications and whether transferred amounts are received by the Single State Agency for each program.

	<i>Department of Education</i>	<i>UVM/VCHIP</i>	<i>Local Schools</i>	<i>“Other” Designated Agencies</i>
<i>Receipt of Certification</i>	<i>Annually</i>	<i>Quarterly</i>	<i>Quarterly</i>	<i>Annually</i>
<i>Transferred Amounts received by Single State Agency</i>	<i>No</i>	<i>No</i>	<i>No</i>	<i>No</i>
<i>Timing for Receipt of Transferred Amounts</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>

- e. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Response – The Agency of Human Services (AHS), the Single State Agency, receives certification from the public agency that the expenditures are eligible for FFP. The public agency also provides supporting documentation that is reviewed by AHS. All funding is identified by the Vermont Legislature.

- f. For any payment funded by CPEs or IGTs, please provide the following:
- (i) a complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (state, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority; and
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response – The non-Federal share of all Medicaid payments are funded through appropriations from the Vermont Legislature. Included in this appropriated amount is a limited amount of CPEs from local education agencies and local designated mental health/developmental service agencies. The CPEs directly support health

care related services. The table below details the CPE amounts as laid out in the SFY 2009 Appropriations bill.

CPE Entity	Operational Nature	Total Amount Certified and Appropriated (State Share)	Total Medicaid Expenditures (State and Federal)	General Taxing Authority
<i>Local Education Agencies</i>	<i>Governmental Entities</i>	\$29,107,624	\$71,605,471	Yes
<i>Local Designated Agencies</i>	<i>Designated Public Entities</i>	\$5,020,198	\$12,349,811	Yes
Total		\$34,127,822	\$83,955,282	

- Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response – *Payments for services are made only for eligible services provided to enrolled individuals. Payments are based on existing fee schedules and rate methodologies; Vermont’s rate methodologies are intended to reimburse providers for the reasonable costs of providing such services. While a limited number of supplemental and enhanced payments are available, such payments are intended to recognize the additional, reasonable costs of particular services and address conditions within the Vermont health delivery market. Supplemental and enhanced payments are as follows:*

- 1) Enhanced payments occasionally are made to reimburse very costly cases for residents with unique and specialized physical conditions (e.g., ventilator patients). The amount of enhanced payment is determined on a case-by-case basis and is intended to cover the facilities’ increased costs of providing care.*

- 2) Quality incentive payments are available to nursing facilities. Each year, up to five quality incentive awards of \$25,000 each are made to Medicaid participating facilities based on certain published criteria related to state survey results and an efficiency element.*

- 3) Supplemental payments are made to dental providers in order to promote access to dental care for Medicaid participants. The total amount of these payments to all dental*

providers varies from year to year, but typically is in the range of \$200,000 to \$300,000, based on the volume of services provided to Medicaid participants. No portion of the payments is returned to the State or any governmental entity.

4. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Response –

State-Owned or Operated Facilities

There are only two publicly-owned facilities in the State: the Vermont Veterans Home and the Vermont State Hospital.

The Vermont Veterans Home is the only nursing facility owned and operated by the State. The Vermont State Hospital also is an inpatient psychiatric facility. The rates for this home are based on actual costs. The final rates for state owned facilities are set retroactively based on their settled cost report for the period which determines their actual reasonable allowable costs. Interim rates are based on a budget estimate of the reasonable allowable costs providing services. At the time the cost report is settled, if the amount actually paid under the interim rate exceeds the amount that should have been paid for the period using the final rate, the facility must return the excess payments to the state, which then accounts for the federal share according to federal reporting requirements. No other Medicaid payments are made. Therefore, payments will not exceed the upper payment limit.

The Vermont State Hospital does not receive Medicaid funding.

Non-State Government Owned or Operated

There is a Veterans' Administration hospital located in White River Junction. It is funded with all federal dollars and therefore, there is no state upper limit calculation.

Privately Owned or Operated

The state makes reasonable estimates of the amounts that Medicare would pay for services furnished by privately-owned and operated providers based on historic data from previous periods and current Medicare payment rates.

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

- a. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Response – *No public provider receives payments in excess of costs. A cost settlement occurs for the Vermont Veterans Home which ensures that Medicaid payments do not exceed the reasonable costs of providing services. If the amount actually paid under the interim rate exceeds the amount that should have been paid for the period using the final rate, the facility must return the excess payments to the state which in turn accounts for the federal share of such recoupments.*

The Agency of Human Services (AHS), the Single State Agency, makes capitation payments to the Office of Vermont Health Access, the State’s publicly-operated managed care entity. These capitation rates are established and certified by an independent actuary on an annual basis.

- b. If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

Response – *No public provider receives payments in excess of costs.*

- c. If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response – *No public provider receives payments in excess of costs.*