

## **SECTION IV.10.           Flexible Choices**

### **A. Definition**

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

### **B. Flexible Choices Standards**

Eligible Flexible Choices participants, who employ, manage and supervise their services within the Choices for Care (CFC) program must:

1. Meet all clinical and financial eligibility criteria for Choices for Care, and
2. Meet criteria for Participant or Surrogate Direction established by Choices for Care, Employer Certification. (*Refer to the Employer Handbook and Employer Agent Certification Form*)

### **C. Provider Types**

The following provider types are approved to provide Flexible Choices services when authorized by DAIL:

1. Consultant Agency (*Revenue Code 079*)
2. Participant or Surrogate-Directed Employees hired by Certified Employers via an Intermediary Services Organization (*Revenue Codes 071*)

### **D. Approved Activities**

1. Consultant Services: The Flexible Choices consultant assists the participant/surrogate in the development and management of the Flexible Choices budget. Consultants are responsible for the following approved activities:

- a. Answering questions about the Flexible Choices and CFC program.
- b. Advising the participant in how to gain access to needed services.
- c. Coordinating assessments and reassessments of the participant.
- d. Developing an allowance.
- e. Educating and supporting participants/surrogates in their role as employers.
- f. Assisting participants in the development of the budget.
- g. Assuring that the participant has an emergency back-up plan in place.
- h. Monitoring the services included in the participant's budget.
- i. Ensure the service provided through the budget is meeting the care needs of the participant.

- j. Certifying the ability of a participant or surrogate employer to manage services.
  - k. Reporting suspected cases of abuse, neglect, and exploitation to Adult Protective Services.
  - l. Reporting suspected cases of Medicaid Fraud to the State Medicaid Fraud Unit.
  - m. Maintaining availability during regular working hours.
2. The Allowance: The allowance is the number of dollars the participant has available to pay for the participant's care needs. The allowance is calculated into a monthly allocation and then broken into a two week budget.

The allowance amount is derived from the participant's assessed functional ability and personal care needs and a predetermined "base rate" calculation. If the participant's needs have changed since his or her most recent assessment, the RN contracted through the Consultant Agency will complete a new assessment, and the allowance will be based on that assessment. Specific allowance amounts will be derived from three components:

- a. *a base amount which will be the same for all participants:*

The base rate is the following costs, based on participant/surrogate directed rates and pro-rated for monthly increments:

- i. Case Management
- ii. Respite/Companion Services
- iii. Personal Emergency Response Services (at \$30/month)
- iv. Equipment/home modifications
- v. Fiscal ISO fees.

The base rate will change as the participant/surrogate rates for these base services change across Choices for Care.

- b. *a personal care amount:*

The personal care component is determined by multiplying the hours needed, as approved on the current Service Plan, by the participant/surrogate personal care hourly rate, and add in the monthly base rate.

- c. *an adult day amount:*

For participants receiving Adult Day services, this is calculated by taking the number of hours of Adult Day services in the currently approved Service Plan and multiplying it by the current Choices for Care Adult Day hourly rate. That sum is then added to the base and personal care amounts. Any allowance amount which arises from participation in Adult Day services may be spent only on Adult Day services, or for care at times the participant is scheduled for Adult Day services but is not able to attend. Should participants stop, start or modify their adult day participation, their allowance amounts will be adjusted accordingly by the RN and approved as noted below.

3. **The Budget:** The budget details the plan by which the participant will spend their allowance to meet their needs, including emergency and back-up coverage. The consultant and the participant, along with whomever the participant asks for support, develop the budget after the allowance has been determined (Budget form – CFC 833).

The budget is broken into the following categories:

a. *Administrative fees:*

These are the monthly fees for the Consultant Agency and the Fiscal ISO. They are the same for all participants in the Flexible Choices option and are billed monthly.

b. *Personal care:*

The participant may determine how many hours of care they require and the rate at which they will pay their workers. Pay rates must not go below legal minimum wage standards and not out of line with prevailing regional wage standards for the work performed. The budgeted cost of personal care will include the costs of employer taxes.

c. *Adult Day services:*

These will match directly the dollar value of Adult Day services approved in the current Service Plan. This budget category may be used to pay for personal care hours provided at a time when the participant was scheduled to attend Adult Day services but could not due to either weather, illness or unscheduled closure of the Adult Day program.

d. *Other Services:*

These are activities provided by a professional in their professional capacity; e.g., nursing or occupational therapy. A “professional” is generally defined as someone licensed or certified by the state to perform a certain task.

e. *Goods:*

These are all other items and activities that do not fit into any other category. This includes tangible items, but also includes things such as health club memberships, yard and home maintenance and transportation.

f. *Cash:*

The participant may receive up to \$50 per two week period in cash. This is to purchase goods or services that are not amenable to billing or vouchers, such as cab rides or the neighbor who shovels the sidewalk.

g. *Savings*:

If a participant does not spend the entire allowance in a two week period, the unspent sum may be carried over to the future as savings. Participants may not carry over more than \$500 in savings from one state fiscal year (July 1 – June 30) to the next.

There are two kinds of savings:

- i. *Specified Savings*: These are savings that are directed towards a specific purchase. There is no limit on how large these savings can get except as noted above.
- ii. *Rainy Day Savings*: These are savings for expected costs that might arise. These savings cannot exceed 100% of the participant's monthly allocation.

## **E. Budget, Employer Responsibilities & Fiscal ISO**

1. Participant Goals and Budget Development: The budgeting process is person centered and begins with the participants' identifying goals for maintaining or enhancing their health, wellbeing and independence at home that they want to meet using their allowance. These goals guide not only the budget development process but also the monitoring and evaluation process (See "Monitoring"). The items in the budget have to clearly relate to the participant's goals, identified needs and the maintenance of the participant's health, wellbeing and independence at home.

If the participant chooses to purchase services which are regularly available Choices for Care services, i.e. personal care, companion or respite services from an agency, adult day services, case management or personal emergency system services, these will be budgeted by the participant and billed by the agency to the participant at the agency's regular long-term care Medicaid rate.

The budget may include funds that would contribute to the cost of the emergency back-up plan.

Budgets are agreed upon by the consultant and the participant. Either the participant or the consultant may consult with DAIL staff if they have questions or if they feel that they need assistance from a third party to resolve difficult issues.

2. Employer responsibilities: The role of the participant/surrogate employer under Flexible Choices is outlined in the *Choices for Care /Flexible Choices Employer Handbook*.
3. The Fiscal Intermediary Services Organization: Under Flexible Choices, all Choices for Care expenses incurred by participants are billed through the Fiscal Intermediary Services Organization (ISO). Fiscal ISO services are provided by the current State Contracted Fiscal

ISO. All charges, except consultant and Fiscal ISO fees, require the participant's signature for payment. Fiscal ISO services are  
*Payroll:* Participants' employees are paid according to procedures listed in the *Choices for Care/Flexible Choices Employer Handbook*. If a participant's payroll expenses are greater than the amount allotted for those costs, the participant grants The Fiscal ISO the authority to spend from other budget categories to allow them to cover payroll. The order in which these funds are drawn is as follows:

- a. Savings
- b. Cash
- c. Goods
- d. Services

If there are not sufficient funds to cover the payroll, the Fiscal ISO will inform the participant and the consultant of the situation. If possible, those covered personnel costs will be covered in the next payroll, although the employer is ultimately responsible for covering his or her payroll. The Fiscal ISO informs the participant via telephone whenever they have to pull money from other budget items to cover payroll. They inform the consultant if there appears to be a pattern with the participant's being unable to manage his care within the budgeted payroll amount.

*Goods and Services:* The procedure to purchase goods and services is as follows:

- a. All specified goods, services or savings must be documented in the participant's budget. The participant is responsible for covering all purchases they make which are not in their budget or have not been approved. Participants submit a Non-payroll Reimbursement Form to the consultant including documentation of the good or service to be purchased and total cost.
- b. The consultant checks the Non-payroll Reimbursement Form against the participant's budget and, if the item is allowable, the consultant approves the request and forwards it to the Fiscal ISO.
- c. The Fiscal ISO cuts a check for the agreed upon amount written out to the vendor and forwards it to the participant (the participant can request the check go directly to the vendor) who completes the purchase.
- d. If something is paid for out of pocket the participant needs to submit the Non payroll reimbursement for and proof of payment for the purchase.

*Cash:* To receive a cash payment:

- a. Participants request their cash allocation via a Non-payroll Reimbursement Form. After the first cash allocation, participants will be responsible for tracking how they spend their cash.

- b. Checks are sent at the end of the pay period after payroll checks have been processed. They appear to the participant as a check written out to them from the Fiscal ISO.
- c. Whenever possible, participants are expected to acquire receipts to document how they spent this allocation.

*Participant Financial Statements:* Participants receive a financial statement from the Fiscal ISO after each payroll. This includes a beginning and ending balance and an itemized listing of all expenditures during that pay period. It also includes current accrued savings. A copy of this report also goes to the consultant.

*Billing Medicaid:* The Fiscal ISO is responsible for billing Vermont Medicaid for actual costs. Vermont Medicaid will reimburse requests for payment for any Long-term Care Medicaid service from only one provider (the Fiscal ISO) for dates of service billed using the Flexible Choices codes.

## **F. Limitations**

1. The Consultant Agency services are limited to one monthly fee for each participant enrolled, which is deducted on the first Fiscal ISO pay date of the month.
2. Consultants shall not perform employer activities such as completing or processing payroll forms, completing payroll documentation and submission, hiring, firing and training employees and coordinating the delivery of services.
3. Consultants shall not assist participants with accessing services outside Choices for Care such as housing and public benefits (Food Stamps or Fuel Assistance).
4. FC services as defined in this section are limited to participants approved by DAIL for Choices for Care services in the home-base setting.
5. FC services are limited to the services identified in the budget and approved by the Consultant Agency.
6. A spouse or civil union partner shall not be paid to provide assistance with Instrumental Activities of Daily Living (IADLs).
7. FC employees with a substantiated record of abuse, neglect, or exploitation of a child or a vulnerable adult shall not be paid to provide CFC services (*DAIL Background Check Policy*).
8. FC employees who have been excluded from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General shall not be paid to provide CFC services (*DAIL Background Check Policy*).

9. FC employees who have a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust shall not be paid to provide CFC services (*DAIL Background Check Policy*).
10. A legal guardian, appointed by probate court, may not be paid to provide FC services.
11. A person who receives FC wages to provide transportation for a FC participant may not simultaneously receive mileage reimbursement as a volunteer driver through the VT Medicaid transportation benefit.
12. FC shall not be provided to a participant who has left the state of Vermont for more than 7 consecutive days.
13. Participant or Surrogate-Directed employees (PCA's) must be 18 years of age or older.
14. A Surrogate Employer shall not be paid to provide FC services to the participant for whom they are acting as a Surrogate.
15. CFC shall not be used to provide FC services that are otherwise being purchased privately or paid for through another funding source.
16. FC services shall not contribute to the cost of the participant's room and board in a shared living arrangement (except in a nursing facility).
17. FC employees shall not require the participant to pay privately for services already available through the FC budget.
18. Participants shall spend only up to the amount of money they have available from their FC allowance.
19. The FC budget shall not cover the following:
  - a. Anything in conflict with Medicaid regulations.
  - b. Room and board for the participant: This includes rent/mortgage payments as well as payment for temporary lodging (e.g., hotels). It also includes normal food and toiletry purchases. Special foods or supplements that are indicated by the participant's needs may be allowable.
  - c. Gambling, alcohol and recreational drugs, both legal and illegal.
  - d. Items covered by other programs: This includes many items of durable medical equipment which are covered by other insurance, including Medicare and traditional Medicaid.

- e. Recreational equipment recreational equipment that is not linked to maintaining independence, health or safety, will typically not be covered.
- f. Routine home costs: Utility bills and routine home maintenance, such as painting or roofing, typically fall under “room and board” and will not be allowed. In extraordinary situations where the participant’s independence is at stake, a one-time expenditure may be allowed. Even in this case, however, all other possible resources need to have been exhausted first.
- g. Clothing: Since clothing costs are generally included in a community maintenance allowance for Medicaid eligibility, participants are assumed to have adequate resources to cover these costs. Specialized clothing which relates to the documented needs of the participant, e.g., special shoes to encourage safe ambulation, are allowed.
- h. Over the counter medications shall not be covered unless they cannot obtain be covered by insurance and the participant has no patient share obligation.