Choices for Care

Vermont Long-Term Services & Supports

Program Operations Manual

Highest & High Needs Group

Revised July 2020

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DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
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https://asd.vermont.gov/

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Manual Updates Log

August 2015: Added Section V.16 ICD 10 Policies & Procedures section to reflect new process for managing ICD10 billing codes.

May 2016: Updated Preface section to reflect the Global Commitment consolidation (January 2015) and updated State central office address.

November 2018: Updated Universal Provider Standards, Adult Family Care, Monitoring Procedures and Enrollment & Billing to reflect federal HCBS rules and revised Adult Family Care standards.

March 2019: Updated ERC section: Deleted Case Management Services paragraph under #8 and added 9. Case Management and 10. Assistive Community Care Services (ACCS).

July 2019: Updated Section IV.6 Assistive Devices & Home Modifications to reflect current policy

PREFACE

The Choices for Care program operates as a "specialty" service within the State's Global Commitment to Health 1115 waiver (GC). This program provides long-term services and supports to elderly or physically disabled Vermont adults who are found eligible by the Department of Disabilities, Aging and Independent Living (the Department or DAIL). The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to either nursing facility care or home and community-based services, consistent with their choice. The Choices for Care waiver is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with GC CMS Special Terms and Conditions of participation.

The Department has developed this policies and procedures manual for the purpose of describing the required eligibility criteria, services and program procedures to assist individuals, case managers and service providers in planning and managing services. This manual shall act as a companion to existing Vermont State regulations.

The Department shall revise and distribute this manual to provider agencies and other interested parties as necessary. A current version will be maintained online at the DAIL website. Please forward any comments or suggestions regarding this manual to "Choices for Care" Administration, Vermont Department of Disabilities, Aging and Independent Living, 280 State Drive, HC2 South, Waterbury, VT 05671-2070, (802) 241-0294.

This manual is dedicated to the caregivers and staff throughout Vermont who work diligently to support individuals to live with dignity and respect in the setting of their choice. Without their ongoing commitment to serving Vermonters, the Choices for Care program would neither exist nor succeed.

Glossary of Terms

1. **AAA:** Area Agency on Aging
2. **Authorized Agency:** Agencies authorized by the Department of Disabilities, Aging and Independent Living (DAIL) to provide adult family care to eligible participants. This includes oversight and management of Adult Family Care (AFC) services and payment to AFC Homes.
3. **Adult Family Care:** A 24 hour care and support option in CFC in which participants live in and receive services in an AFC Home which is contracted by an Authorized Agency.
4. **Adult Family Care Home:** A home established and operated for the purpose of providing individualized supports in an environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity for up to two individuals, unrelated to the operator, enrolled in Choices for Care. The home must be contracted with an Authorized Agency in order for the home provider to receive a "Difficulty of Care Payment" (tax-free stipend).
5. **Adult Family Care Coordinator (AFCC):** Coordinates care for Adult Family Care participants throughout the continuum of care to ensure that care is timely, appropriate, of high quality and cost effective. The AFCC works closely with the Case Manager, primary care providers, other health care professionals and team members, clinics, internal or external services, and community agencies. The AFCC provides coordination and planning of multiple health care services; acts on behalf of the AFC participant to ensure that necessary clinical services are met and that communication with the Case Manager is timely and accurate.
6. **Activities of Daily Living (ADL):** ADL's means dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home, and eating.
7. **Adult Protective Services (APS):** The unit within the Division of Licensing and Protection (DLP) responsible for processing, investigating and prosecuting reports of abuse, neglect and exploitation against vulnerable adult Vermonters.
8. **Agency:** An entity that provides care or services to participants on the Choices for Care program.
9. **Agency of Human Services:** The Vermont state agency responsible for oversight of the Department of Disabilities, Aging and Independent Living (DAIL).
10. **Applicant:** An individual who has applied to the Choices for Care, VT Long-Term Care Medicaid program to receive services.
11. **Area Resource for Individualized Service (ARIS):** A private non-profit organization currently under contract with the State acting as the Intermediary Service Organization (ISO) for consumer and surrogate directed services.
12. **Assessment:** The tool and process used to document an individual's strengths, needs, and unmet needs as they relate to health, social and functional status. The assessment is used to determine clinical eligibility for Choices for Care, VT Long-Term Care Medicaid.
13. **Authorized Representative:** An individual who has been given legal authority to act on behalf of an applicant or participant.
14. **Caregiver:** A person who provides personal care (for reimbursement or as a volunteer).
15. **Centers for Medicare and Medicaid Services (CMS):** The federal office responsible for approving and monitoring the Choices for Care program.
16. **Choices for Care (CFC):** The program name used to identify the new Vermont Long-Term Care Medicaid, (1115 Waiver) program.
17. **Choices for Care Team:** Previously known as the "Medicaid Waiver Team", the group of

local provider agencies and other relevant organizations which meets on a regular basis to collaborate in managing Choices for Care, VT Long-Term Care Medicaid services, in accordance with the local/regional protocol.

18. **Civil Union:** A legal partnership between people of the same gender, as recognized by Vermont state law.
19. **Consultant:** Consultants work at an agency called Transition II. Consultants work with individuals using the Flexible Choices Option to assist the individual in the development and management of their Flexible Choices budget.
20. **Consumer-Directed Service:** Services directed by the participant, functioning as an employer of paid caregivers.
21. **Critical Incident:** A critical incident is any actual or alleged event, incident or course of action involving the perceived or actual threat to a participant's health and welfare; or any actual or alleged event, incident or course of action involving the perceived or actual threat to his/her ability to remain in the community.
22. **Department for Children and Families (DCF):** The state department within the Vermont Agency of Human Services (AHS) with primary authority for the state financial eligibility determination for Choices for Care, VT Long-Term Care Medicaid services. DCF is also responsible for administration of other state health care and financial benefits for Vermonters.
23. **Department of Disabilities, Aging and Independent Living (DAIL):** The state department within the Vermont Agency of Human Services (AHS) with primary authority for the state management, approval, and oversight of Choices for Care, VT Long-Term Care Medicaid services.
24. **Department of Vermont Health Access:** The State agency responsible for the management of Medicaid and other publicly funded health insurance programs.
25. **Difficulty of Care Payment:** A tax-free stipend made by an Authorized Agency to an Adult Family Care Home in accordance with IRS rules.
26. **Division of Licensing and Protection (DLP):** The division within the Department of Disabilities, Aging and Independent Living (DAIL) responsible for the licensing and regulation of skilled nursing facilities, residential care homes, assisted living residences, and Medicare certified home health agencies. Adult Protective Services (APS) is located in DLP.
27. **Employee:** A person who provides care or services and receives reimbursement from another individual or organization.
28. **Employer:** A consumer, surrogate, or organization that manages and supervises Choices for Care, VT Long-Term Care Medicaid services employees.
29. **Estate Recovery:** The process in which the Department of Vermont Health Access (DVHA) may recover the cost of Choices for Care, Long-Term Care Medicaid services that have been provided to an individual and paid for by the State of Vermont. The process of Estate Recovery occurs after the individual has passed away and is done through the probate court process.
30. **High Needs Group:** Individuals who have been found to meet the high needs group clinical eligibility criteria and have been authorized to receive services.
31. **Highest Needs Group:** Individuals who have been found to meet the highest needs group clinical eligibility criteria and have been authorized to receive services.
32. **Home Health Agency (HHA):** A Medicare Certified home health care agency authorized to provide Choices for Care, VT Long-Term Care Medicaid services.
33. **Instrumental Activities of Daily Living (IADL):** Means meal preparation, medication management, phone use, money management, household maintenance, housekeeping,

laundry, shopping, transportation, and care of adaptive equipment.

34. **Independent Living Assessment (ILA):** An assessment tool used to document an individual's strengths and needs as they relate to health, social and functional status in the home-based setting.
35. **Intermediary Service Organization (ISO):** A private non-profit organization or corporation which provides payroll management services for employers (including direct payments to employees; federal and state income tax withholding, reporting, and payments; workers compensation insurance; federal unemployment taxes; state unemployment taxes; submission of Medicaid claims; and receipt of Medicaid payments).
36. **Legal Representative:** An individual who has the legal authority, via a power of attorney document or court appointed guardianship, to make decisions or perform certain activities on behalf of another person.
37. **Long-Term Care:** Care and services provided to an individual on an ongoing basis for the purpose of accomplishing Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). Long-term care is "non-acute" in nature.
38. **Minimum Data Set (MDS):** An assessment tool used by licensed nursing facilities to document an individual's strengths and needs as they relate to health, social and functional status in a nursing facility setting.
39. **OASIS:** An assessment tool used by Medicare certified home health agencies to document an individual's strengths and needs as they relate to health, social and functional status while receiving Medicare/Medicaid funded home care services.
40. **Participant:** A person who has been found eligible and receives Choices for Care, VT Long-Term Care Medicaid services.
41. **PASRR:** "Pre-Admission Screening and Resident Review", used to identify a need for active treatment due to a mental illness or developmental disability.
42. **Patient Share:** An individual's monthly share of the cost of Choices for Care, Long-Term Care Medicaid services as determined by the Department for Children and Families (DCF). The amount of an individual's patient share (if any) is based on the individual or couples monthly income.
43. **Personal Care Attendant (PCA):** A person who is employed to provide personal care services.
44. **Personal Care Worksheet:** The tool used together with the Independent Living Assessment (ILA), to estimate the amount of personal care services that may be provided in the home-based setting.
45. **Person Centered Planning:** Person centered planning is a process of continual listening and learning; focused on the strengths of the individual, their goals now, and for the future; and acting upon this in alliance with their family and friends toward the objective of community inclusion and power in sharing the decision-making.
46. **Primary Caregiver:** A person who provides personal care and/or supervision on an ongoing basis, without pay.
47. **Provider:** An individual, organization, or agency that has been authorized by the Department to provide Choices for Care, Long-Term Care Medicaid services.
48. **Reimbursement:** Payment for services which have been provided by a person or organization.
49. **Residential Assessment (RA):** An assessment tool used by licensed residential care homes and assisted living residences to document an individual's strengths and needs as they relate to health, social and functional status in a residential care setting.
50. **Room and Board:** Payment made to a homeowner or Licensed Residential Care

Home/Assisted Living Residence for lodging and meals, which includes the cost of rent, all common utilities and telephone, home maintenance and repair, and food. Medicaid only pays for room and board in a nursing facility.

51. **Service Plan:** A form which identifies the Choices for Care Long-Term Care Medicaid services which may be provided to a participant within a specified time period, and which when approved by DAIL gives provider organizations authority to provide services and submit claims for reimbursement.
52. **Spouse:** A legally husband, wife, or (pursuant to Vermont statute) a civil union partner.
53. **Supervision:** Training, instructing, and giving performance feedback (positive or negative) to a worker.
54. **Surrogate:** A person who acts as an employer and manages employees on the behalf of the participant.
55. **Surrogate-Directed Services:** Services which a surrogate directs on behalf of a participant, functioning as the employer of paid caregivers (employees).
56. **Utilization Review (UR):** A Department of Disabilities, Aging and Independent Living (DAIL) review process intended to assure that the Choices for Care, VT Long-Term Care Medicaid service type and volume are appropriate to meet the needs of eligible individuals, while remaining as efficient as possible.
57. **Volunteer:** A person who provides unpaid care or services in a formal volunteer relationship, and who is neither a family member nor a paid employee.

SECTION I. General Policies

A. Choices for Care services shall be based on person-centered planning, and shall be designed to ensure quality and to protect the health and welfare of the participants receiving services.

B. Choices for Care services shall be provided in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. The Department of Disabilities, Aging and Independent Living (DAIL) shall manage Choices for Care services so as to use resources efficiently, and to maximize the benefits and services available to the greatest number of eligible participants.

C. DAIL shall administer the Choices for Care waiver in accordance with Choices for Care 1115 Long-Term Care Medicaid Regulations, the CMS terms and conditions, and applicable state and federal law.

D. Eligible participants shall be informed of feasible service alternatives.

E. Consistent with federal terms and conditions, DAIL shall have the authority to implement different elements of the Choices for Care program at different times.

F. DAIL encourages any applicant or participant who disagrees with a decision to contact the DAIL staff person who made the decision to try to resolve the disagreement informally.

SECTION II. Eligibility

A Choices for Care application is required for any person who needs Vermont (VT) Medicaid coverage for long-term services and supports and believes they may meet the clinical and financial eligibility standards outlined in this section. An application is not required for people in need of medical care or short-term rehabilitation services covered by insurance such a Medicare, Vermont Medicaid, Veteran's benefits (VA) or private insurance. ***People must refer to their specific insurance coverage standards for medical care and rehabilitation coverage at home or in a nursing facility.*** Refer to section V.1 Application and Eligibility Determination Procedures for detailed instructions on the Choices for Care application process.

I. Standards for Eligibility

To be eligible for the Choices for Care program: (*CFC Regulations, Section IV. Eligibility*)

1. An eligible individual must be a Vermont resident aged 18 or older who meets both clinical and financial eligibility criteria.

2. Choices for Care shall not replace or supplant services otherwise provided under other 1915c Medicaid waivers or other 1115 Medicaid waivers (e. g. Community Rehabilitation and Treatment). Thus, to be eligible for services other than nursing facility services, an individual must have a functional physical limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. Individuals whose need for services is due to a developmental disability, autism, or mental illness shall not be eligible for services.

3. Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicaid and Medicare.

NOTE: Individuals choosing a nursing home setting who have an active treatment plan for a mental health diagnosis or developmental disability must have a Step II PASRR screening completed prior to admission to the nursing home.

II. Short-term Rehab in a Nursing Facility

NOTE: Refer to Section V.1 Application and Eligibility Determination Procedures; subsection K. Short-term Rehab in a Vermont Nursing Facility for more detailed procedures.

A. Dual Medicare/Medicaid Stays: For individuals with both Medicare hospital coverage and Vermont Medicaid coverage and who meet the Medicare eligibility standard for "Coverage for Extended Care" in a nursing facility (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf), these individuals are not required to

submit a Choices for Care application. Instead, the facility shall verify eligibility for Medicare and Vermont Medicaid coverage and submit a notice within 10 days of admission and discharge to DCF using the CFC 804C form (06/14). DCF will enter a long panel for the stay using the "Highest Need" category. After the nursing facility bills and is reimbursed by Medicare, Vermont Medicaid will automatically cover the co-insurance "crossover claims" from day 21 through day 100, for as long as Medicare pays. Nursing facility crossover claims will be paid out of the Choices for Care budget.

B. Vermont Medicaid Only Stays: People with Vermont Medicaid who are not eligible for Medicare coverage (or any other form of insurance coverage) for short-term rehab in a nursing facility, the Vermont Medicaid benefit package includes a short-term Skilled Nursing Facility (SNF) benefit that is limited to not more than 30 days per episode and 60 days per calendar year.

Admission of a person with Vermont Medicaid to a Skilled Nursing Facility (SNF) per the benefit outlined above is based on a physician's order for SNF services with documentation of medical necessity for the treatment of illness or injury. The admitting diagnosis must support all treatment and therapies ordered and maintain that the service cannot be provided at a lower level of care.

As of June 1, 2014, individuals are not required to submit a *Choices for Care* application for short-term SNF stays. Instead, the SNF will verify Vermont Medicaid coverage and submit a notice of admission and discharge to DCF using the CFC 804C form (06/14). DCF will enter a long panel for the stay using the Highest Need category. The facility will submit Vermont Medicaid claims for coverage using revenue code 128 and will be paid out of the Choices for Care budget.

Refer to the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*, for more eligibility and coverage details.

III. Choices for Care Clinical Eligibility

Determination of clinical eligibility is a skilled nursing function conducted by a registered nurse (RN). Accurate clinical assessment requires the consideration of a number of variables that affect an individual's clinical eligibility. In certain cases the attending physician's input will be sought regarding medical conditions. The RN will consider the required variables including medical conditions when making a determination of the individual's clinical eligibility. In addition, the RN may determine that an individual currently enrolled in the Choices for Care program has significantly improved and because of the improvement, no longer meets clinically eligibility criteria. In such an instance, the RN must determine if the individual's condition will worsen if required to leave the program. In other instances, the RN must determine whether an individual is currently receiving adequate services to meet identified needs from other non-waiver sources. If an individual's needs could be met through private and/or other community resources (whether or not they are), the individual will not be eligible for the Choices for Care program.

A. Highest Need Group

Individuals who apply and meet any of the following eligibility criteria shall be eligible for and enrolled in the Highest Needs group:

1. Individuals who require extensive or total assistance with at least one of the following Activities of Daily Living (ADL):

Toilet use	Bed mobility
Eating	Transferring

   AND require *at least* limited assistance with any other ADL.

2. Individuals who have a severe impairment with decision-making skills OR a moderate impairment with decision- making skills AND one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered:

Wandering	Verbally Aggressive Behavior
Resists Care	Physically Aggressive Behavior
Behavioral Symptoms	

3. Individuals who have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:

Stage 3 or 4 Skin Ulcers	Ventilator/ Respirator
IV Medications	Naso-gastric Tube Feeding
End Stage Disease	Parenteral Feedings
2nd or 3rd Degree Burns	Suctioning

4. Individuals who have an unstable medical condition that require skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to at least one of the following:

Dehydration	Internal Bleeding
Aphasia	Transfusions
Vomiting	Wound Care
Quadriplegia	Aspirations
Chemotherapy	Oxygen
Septicemia	Pneumonia
Cerebral Palsy	Dialysis
Respiratory Therapy	Multiple Sclerosis
Open Lesions	Tracheotomy
Radiation Therapy	Gastric Tube Feeding

5. Special Circumstances: Individuals who do not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the Department determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. The Department may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

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

6. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, meet any of these Highest Needs eligibility criteria shall be enrolled in the Highest Needs group.

7. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

B. High Need Group

Individuals who meet any of the following eligibility criteria shall be eligible for the High Needs group and may be enrolled in the High Needs group:

1. Individuals who require extensive to total assistance on a daily basis with at least one of the following ADLs:
   Bathing — Dressing
   Eating — Toilet Use
   Physical assistance to walk

2. Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following:
   Gait training — Speech
   Range of motion — Bowel or bladder training

3. Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following:
   Bathing — Dressing
   Eating — Toilet Use
   Transferring — Personal hygiene

4. Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:
   Constant or frequent wandering
   Behavioral Symptoms
   Persistent physically or verbally aggressive behavior

5. Individuals who have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including (but not limited to) the following:

Wound Care	Suctioning	Tube Feedings
Medication Injections	End Stage Disease	
Parenteral Feedings	Severe Pain Management	

   AND who require an aggregate of other services (personal care, nursing care, medical treatments and/or therapies) on a daily basis.

6. Special Circumstances: Individuals who do not meet at least one of the above criteria may be enrolled in the High Needs Group when the Department determines that the individual has a critical need for long-term care services due to one of the following:
   a. Individuals whose health condition shall worsen if services are not provided or if services are discontinued, as determined by the Department, **or**
   b. Individuals whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued, as determined by the Department.

7. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, do not meet Highest Needs eligibility criteria but do meet any of these High Needs eligibility criteria shall be enrolled in the High Needs group.

8. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

IV. Financial Eligibility

A. Eligibility

To be financially eligible, individuals must meet the existing financial criteria for Vermont Long-Term Care Medicaid as determined by the VT Department for Children and Families (DCF), Economic Services Division (ESD). DCF-ESD uses pre-determined income and resource limits, allowing for certain deductions and exclusions.

B. Patient Share

In some cases, individuals may be responsible for paying a portion of the cost of their services (patient share), as determined by DCF-ESD. The amount of the patient share, if any, is based on the individual or couple's monthly income after certain allowable deductions. If a patient share is due, DCF will indicate on the written notice the amount of the patient share and the name of the provider to whom the payment is made each month.

C. Coverage

When an individual is found financially eligible for Choices for Care, Long-Term Care Medicaid the State pays for services as determined by the setting. In addition, the individual becomes eligible for all other Vermont Medicaid state plan health benefits including payment for doctors, hospital stays and prescriptions.

D. Estate Recovery

The Department of Vermont Health Access (DVHA) has the legal authority to recover the cost of Choices for Care services that have been provided to the individual and paid for by the State of Vermont. The process of Estate Recovery occurs after the individual has passed away and is accomplished through the probate court process. Existing State and Federal laws determine how and when DVHA may recover costs from an individual's estate.

NOTE: Contact the local DCF-ESD office for more information regarding financial eligibility, patient share, health benefits coverage, or estate recovery 1-800-479-6151.

SECTION III. Universal Provider Qualifications & Standards

A. Definition

A "provider" of services for the Choices for Care (CFC) is defined as any entity that has been authorized by the Vermont Agency of Human Services, Department of Disabilities, Aging and Independent Living (DAIL) to provide, and be reimbursed by the State for CFC services as outlined in this manual.

B. Provider Qualifications

All Choices for Care (CFC) providers must:

1. Be authorized by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) to provide CFC services; and

2. Be enrolled with as a Vermont Medicaid provider with a current Department of Vermont Health Access, General Enrollment Agreement.

3. Demonstrate compliance with Universal Provider Standards.

C. Provider Standards

Universal provider standards apply to all Choices for Care providers. Service-specific standards are found under the application section of this manual. Wherever possible, a link to reference sites have been provided.

All Choices for Care (CFC) providers shall:

1. Comply with the Department of Vermont Health Access (DVHA), Vermont Medicaid General Provider Agreement.

2. Provide services in a cost-effective and efficient manner, preventing fraud, waste and abuse.

3. Comply with all service-specific regulations, standards and procedures.

4. Ensure that all staff with direct participant contact has passed a background check, according to the DAIL Background Check Policy.

5. Ensure that all staff with direct participant contact reframe from smoking in the presence of participants at all times.

6. Maintain and comply with internal complaint procedures.

7. Maintain a robust conflict of interest policy and procedures for identifying and mitigating conflicts that may arise between the interests of the participant and that of the provider or their staff.

8. Comply with service-specific Home and Community-Based Services (HCBS) rules regarding person-centered planning and setting requirements. (42 CFR Subpart G, 441.3 (c), (1) - (4))

9. Follow Vermont statute 33 V.S.A. Chapter 69 regarding mandated reporting of abuse, neglect, and exploitation.

10. Maintain all records according to the Vermont Medicaid General Provider Agreement.

11. Upon request, furnish records and information regarding any Medicaid claim for providing such service to DAIL, DVHA, the Vermont Attorney General's Medicaid Fraud Control Unit (MFRAU hereafter), and the U.S. Secretary of Health and Human Services (Secretary hereafter).

12. Demonstrate to DAIL that they have sufficient expertise and capacity to meet the needs of the target population, including effective working relationships with other local or regional providers and agencies.

13. Ensure that staff has the skills and/or training required to meet the needs of the participant.

14. Ensure the volume of services are provided and billed within the limits of the approved CFC service authorization.

15. Ensure the participant is directing their services to the fullest extent they are able.

16. Maintain a copy of legal representation documents (e.g. Power of Attorney, Guardian) that authorize a person to provide direction or decisions on behalf of the participant.

17. Fully inform participants and their legal representative of their rights and responsibilities in working with the agency.

18. Inform participants and their legal representatives of the provider complaint process.

19. Notify participants and their legal representatives in writing when the provider initiates the discontinuation or reduction of services, including appeal rights.

20. Assist the participant and legal representatives in understanding their program appeal rights when the State initiates the discontinuation or reduction of services, including appeal rights.

21. Ensure that all participants and their legal representatives are informed about the Vermont Long-Term Care Ombudsman office and are offered access to those services when needed or requested.

22. Maintain accurate and complete documentation of services provided to the participant.

23. Abide by principles of confidentiality, including HIPAA Regulations and all other applicable confidentiality policies and laws.

24. Comply with all laws regarding employment, including minimum wage, the provision of workers' compensation insurance and unemployment insurance to employees. http://labor.vermont.gov/.

25. Notify the State immediately in the event the provider is at risk of closure or termination of program enrollment.

26. Maintain a written process for monitoring the delivery of services to ensure:
    a. ongoing compliance with Universal Provider Qualifications and Standards,
    b. ongoing compliance with service specific standards,
    c. quality of services provided, and
    d. areas for improvement are identified and acted upon.

27. Fully participate in all State and federal compliance, licensure/certification and quality management activities.

SECTION IV. Services

A. Services by Setting

Choices for Care (CFC) services include, by setting:

1. Home-Based Services Settings:
   a. Home-Based ("Traditional")
      i. Case Management *(revenue code 070)*
      ii. Personal Care *(revenue codes 072, 077 & 081)*
      iii. Adult Day *(revenue code 078)*
      iv. Respite Care *(revenue codes 073, 074, 075, 080, & 084)*
      v. Companion *(revenue codes 073, 075, 080, & 088)*
      vi. Personal Emergency Response System *(revenue codes 082 & 083)*
      vii. Assistive Devices and Home Modifications *(revenue code 076)*
   b. Flexible Choices *(revenue codes 071 & 079)*
   c. Adult Family Care *(revenue code 086)*

2. Enhanced Residential Care (ERC) Setting: *(revenue codes 092, 093, 094 & 090)*
   ERC services are bundled into a daily rate to include
   a. 24-Hour Supervision
   b. Nursing Overview
   c. Personal Care
   d. Medication Management
   e. Recreational Activities
   f. Laundry Services
   g. Housekeeping Services
   h. In Home Case Management

3. Nursing Facility (NF) Setting: *(revenue codes 120, 128, 130, 169, 182 & 185)*
   Nursing facility services are bundled into a daily rate to include:
   a. Room and Board
   b. Skilled Nursing
   c. Personal Care
   d. Medication Management and pharmacy services
   e. Social Worker Services
   f. Recreation Activities
   g. 24-Hour On-Site Nursing Supervision
   h. Laundry Services
   i. Housekeeping Services
   j. Transportation
   k. Physical Therapy, Occupational Therapy and Speech Therapy
   l. Nutritional and Dietary Services
   m. Maintenance of Resident Clinical Records

NOTE: Refer to specific manual section for detailed service definitions and limitations.

B. Principles

1. CFC services foster respect, dignity, and a sense of well being for the individual being served.

2. CFC services respect individual rights, strengths, values, privacy, and preferences, encouraging individuals to direct and participate in their own plan of care and services to the fullest extent possible.

3. CFC services respect individual self-determination, including the opportunity for individuals to decide whether to participate in a program or activity.

4. CFC services are provided as part of a comprehensive and person centered plan of care, which is developed through collaboration to meet the needs of the individual. All CFC services are coordinated with other services.

5. CFC services are provided in an efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. CFC services attempt to use resources efficiently to maximize the benefits and services available to all individuals.

6. CFC services will not be used to secure improper or inappropriate gain for the provider, provider staff, family members or any other person involved in the individual's care.

C. Desired Outcomes

1. The individual continues to reside in his/her setting of choice.

2. The individual's needs are met, and he or she is as healthy as possible.

3. The individual's optimal level of functioning and independence is achieved or maintained.

4. The individual is satisfied with services.

5. If applicable, primary caregivers receive relief from care giving responsibilities, as well as education and support, and continue to provide care.

6. If applicable, the individual's primary caregiver or family is satisfied with services.

7. Services are provided in an efficient manner, and duplication of effort and services is minimized.

SECTION IV. 1. Case Management Services

A. Definition

"Case Management Services" assist individuals in accessing Choices for Care (CFC), VT Long-Term Care Medicaid services as well as other medical, social, and educational services, regardless of the service funding source. Case Management Services provide detailed needs assessment and assist the individual in creating a comprehensive CFC person centered plan. Case Management Services provide ongoing assessment and monitoring. Case Management Services assist the Department of Disabilities, Aging and Independent Living (DAIL) in monitoring the quality, effectiveness and efficiency of CFC services.

B. Case Management Standards

Case Management providers shall be authorized by the DAIL and comply with the following:

1. DAIL Case Management Standards & Certification Procedures

2. DAIL Case Management Agency Certification Procedures (December 2010)

3. CFC Universal Provider Qualifications and Standards (*Section III.)*

4. CFC Services Principles (*Section IV*.)

C. Provider Types

The following provider types are approved to provide Case Management Services when authorized by DAIL and identified on the individuals Service Plan:

1. Area Agencies on Aging

2. Home Health Agencies *(as defined by State statute)*

D. Approved Activities

Case Management Services includes tasks associated with the following reimbursable activities:

1. Assessment: A comprehensive review of the individual circumstances, including, but not limited to, social, medical, functional, financial and environmental needs.

2. Care-Planning: A person centered process of identifying the goals, strengths and needs of the individual, including those identified in the assessment process. A plan is then developed to identify the services and supports to be delivered in order to meet the individual's needs and goals.

3. Service Coordination: The process by which services are obtained for the individual through coordination with multiple resources and providers.

4. Information and Referral: The process by which the individual is fully informed of available options and assisted with referrals.

5. Monitoring: Ongoing review of the individual's health and wellbeing, functional needs, service utilization, goals and outcomes.

6. Participant & Surrogate Employer Certification: The process of assessing and reassessing an employer's certification for the home-based participant or surrogate directed option.

7. Documentation: Documentation includes all required CFC forms, person centered plan, applications for other services or public benefits and the documentation of ongoing case management activities.

8. Travel: Travel time includes getting to and from participant home-visits (or other face-to-face participant visit) and care-planning meetings related to individual service coordination.

E. Limitations

1. Case Management Services are limited to the "approved activities" for individuals authorized by DAIL for Choices for Care in the Home-Based or Enhanced Residential Care (ERC) setting.

2. Case Management Services are limited to a maximum of 48 hours per individual per calendar year.

3. Case Management Services for are limited to a maximum of 24 hours per individual per calendar year for participants in Adult Family Care.

4. Case Management Services may not be delegated to another case manager except under short-term, temporary situations.

5. Case Management Services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing facility or hospital, when such services are clearly documented as facilitating the individual's return to the community.

F. Additional Case Management

If a participant needs additional case management services the case manager must submit a completed Services Variance Request Form (CFC 813A) requesting a variance to the service volume limit. The request must describe the case management activities provided to the participant and the unique circumstances that led to the utilization of a high volume of hours. It must be demonstrated that the participant's health or welfare may be at risk without additional case management. Case Management services are limited to approved activities only. Activities such as accounting services (banking & bill paying) and transportation are not approved case management activities. Non-approved activities must be provided by other services and supports. Retroactive requests will not be approved unless the request adequately demonstrates there was an immediate need to provide case management services to the individual in excess of the maximum prior to requesting a variance. Case managers are responsible for managing and tracking the volume of case management services allowed.

SECTION IV. 2. Adult Day Services

A. Definition

"Adult Day Services" are community-based non-residential services designed to assist adults with physical and/or cognitive impairments to remain as active in their communities as possible, by maximizing their level of health and independence and ensuring their optimal functioning. Adult Day centers provide a safe, supportive environment where participants can receive a range of professional health, social and therapeutic services. Adult Day services also provide respite. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

Note: Adult Day services for participants living in an Adult Family Care home setting is covered under the Adult Family Care service standards (Section IV.11).

B. Adult Day Standards

Adult Day providers shall be certified by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. Standards for Adult Day Services in Vermont (DAIL)

2. CFC Universal Provider Qualifications and Standards (*Section III.*)

3. CFC Services (*Section IV.*)

C. Provider Types

The following provider type is approved to provide Adult Day Services when authorized by DAIL and identified on the individuals Service Plan:

- Vermont Certified Adult Day Providers

C. Approved Activities

Adult Day Services includes the following approved, reimbursable activities:
1. Assessment
2. Personal Care
3. Therapies
4. Activities
5. Meals
6. Social Outings
7. Nursing Overview
8. Respite
9. Assist in arranging and coordinating Transportation

D. Limitations

1. Adult Day Services are limited to individuals approved by DAIL for services in the home-based setting.

2. Adult Day Services are limited to a maximum of 12 hours per day.

3. Adult Day Services are limited to the hours of operation and capacity of the adult day provider.

4. Adult Day Services are limited to the number of hours indicated on the approved CFC Service Plan.

5. Meals provided as part of Adult Day Services shall not constitute a "full nutritional regimen" for the day.

6. Transportation services are not included and are not reimbursed as part of Adult Day Services. The costs of transporting participants to and from the Adult Day Services site may be eligible for reimbursement under the Medicaid State Plan, as a transportation service.

7. Adult Day Services shall not be reimbursed for individuals residing in a licensed facility (hospital, nursing facility, residential care home, and assisted living residence).

SECTION IV. 3. Personal Care Services

A. Definition

Personal Care Services assist individuals in the home-based setting with activities of daily living (ADL) and instrumental activities of daily living (IADL) that are essential to the health and welfare of the individual.

Note: Personal care in an Adult Family Care home setting is covered under the Adult Family Care service standards (CFC Manual Section IV.11 Adult Family Care). Standards of care provided in a nursing facility or residential care home is covered under the applicable standards and regulations (CFC Manual Section IV.8 & IV.9, and http://www.dlp.vermont.gov/regs).

B. Personal Care Standards

Personal Care Service providers, who employ, manage and supervise personal care attendants within the Choices for Care (CFC) program must be authorized by the DAIL and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations

2. Participant and Surrogate-Directed Employer Responsibilities (Participant/Surrogate Employers only) as outlined in the Employer Handbook.

3. CFC Universal Provider Qualifications and Standards (*Section* III.)

4. CFC Services (*Section IV.*)

C. Provider Types

The following provider's types are approved to provide Personal Care Services when authorized by DAIL and identified on the individuals Service Plan:

1. Home Health Agencies as defined by State statute *(Revenue Code 072)*

2. Participant or Surrogate-Directed Employees hired by Certified Employers via an Intermediary Services Organization *(Revenue Codes 077 and 081)*

D. Approved Activities

Personal Care Services may include the following approved, reimbursable activities when identified on the individual's assessment, service plan or AFC person centered plan:

1. Activities of Daily Living (ADL): ADL's include the following:
   a. Dressing
   b. Bathing
   c. Personal Hygiene

d. Bed Mobility
e. Toileting
f. Assistance with Adaptive Devices
g. Transferring
h. Mobility
i. Eating

2. Instrumental Activities of Daily Living: IADL's include the following:
   a. Meal Preparation
   b. Medication Management
   c. Using the Telephone
   d. Money Management
   e. Household Maintenance
   f. Light Housekeeping
   g. Laundry
   h. Shopping
   i. Transportation
   j. Care of Medical or Adaptive Equipment

E. Personal Care Services, provided in an (Unlicensed) Private Home

A CFC participant may receive Personal Care Services in the home of another person. If the participant is living in the unlicensed home of a person who is not related to them, and is not covered under the Adult Family Care services, the following must apply:

1. The home shall adhere to the standards and limitations for Personal Care Services being provided to the participant in the approved Service Plan.

2. The home shall not be paid to provide respite services.

3. The home shall follow all applicable landlord/tenant laws and Life Safety codes.

4. The home shall adhere to participant rights.

5. The private home shall include the participant and case manager in creating a written room and board agreement. A copy shall be provided to the local DAIL LTCCC and updated as the circumstances change.

6. Allowing home visits by DAIL staff, Ombudsman, Case Managers and other visitors as determined by the participant or legal representatives.

7. The room and board agreement shall reflect a reasonable "market rate" room and board amount and shall assure that the participant maintains adequate spending money. It is recommended that the amount of room and board and personal spending money follow the DAIL Room & Board standards, allowing for at least $115/month in personal spending money (as of 2013).

8. An unlicensed private home shall not provide or be paid to arrange for, care to more than two unrelated people in their home, regardless of the source of payment. (*Refer to the Residential Care Home Licensing Regulations for details http://www.dlp.vermont.gov/regs.*)

9. The unlicensed private home may not require or accept pay for care or services already available to the participant through the CFC Service Plan.

10. The live-in caregiver must communicate with the case manager regarding the participant's needs on a regular basis and participate in regular assessment and monitoring activities.

11. The live in caregiver may not receive payment through CFC for home maintenance and repair, 24-hour care and supervision, room and board or any service paid for by the participant to the live-in caregiver as described in the room and board agreement or in a "contract for care".

E. Limitations

1. Personal Care Services as defined in this section are limited to individuals approved by DAIL for services in the Home-Based setting.

2. Personal Care Services are limited to the maximum hours allocated on the DAIL approved Service Plan.

3. Instrumental activities of daily living (IADLs), not including meal preparation and medication management, are limited to 4.5 hours per week.

4. A spouse or civil union partner shall not be paid to provide assistance with Instrumental Activities of Daily Living (IADLs) as a part of Personal Care Services.

5. Personal Care Attendants 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*).

6. Personal Care Attendants 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*).

7. Personal Care Attendants 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).*

8. Personal Care Services shall not be furnished to individuals who are inpatients of a hospital or nursing facility.

9. A legal guardian, appointed by probate court, may not be paid to provide Personal Care Services.

10. A person who receives wages to provide Personal Care Services may not simultaneously receive mileage reimbursement as a volunteer driver through the VT Medicaid transportation benefit.

11. Personal Care Services shall not be provided to a participant who has left the state of Vermont for more than 7 consecutive days.

12. Participant or Surrogate-Directed employees (PCA's) must be 18 years of age or older.

13. A Surrogate Employer shall not be paid to provide Personal Care Services to the participant for whom they are acting as a Surrogate.

14. CFC shall not be used to provide Personal Care Services that are otherwise being purchased privately or paid for through another funding source.

15. Assistance with meal preparation does not include the cost of food.

16. Medicare Certified Home Health Agencies may place limitations on the delegation of certain Personal Care Services activities according to VT Statute Title 26, Chapter 28 and the State of VT Board of Nursing Administrative Rules (e.g. medication handling).

17. CFC services shall not contribute to the cost of the participant's room and board in a shared living arrangement (except in a nursing facility).

18. A Personal Care Services employee shall not require the participant to pay privately for services already available through the CFC program.

SECTION IV. 4. Respite Care Services

A. Definition of Respite Care

"Respite Care Services" provide planned short term and time limited breaks for unpaid care givers. This specific Respite Care Service applies to people living in the home-based setting and is reimbursed at an hourly rate.

Note: Respite in an Adult Family Care home setting is covered under the Adult Family Care service standards (Section IV.11). Participants may also receive respite in a nursing home or swing bed setting, which is accomplished by a CFC change in setting.

B. Respite Care Standards

Respite Care Services providers who manage and supervise respite employees must be authorized to provide Choices for Care (CFC) services by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations

2. Participant and Surrogate-Directed Employer Responsibilities (Participant/Surrogate Employers only) as outlined in the Employer Handbook.

3. Standards for Adult Day Services in Vermont (*Adult Day providers only*)

4. CFC Universal Provider Qualifications and Standards (*Section III*.)

5. CFC Services (*Section IV*.)

C. Provider Types

The following provider types are approved to provide Respite Care Services when authorized by DAIL and identified on the individuals Service Plan:

1. Home Health Agencies *(as defined by State statute)(Revenue Code 073)*

2. Employees of Certified Participant or Surrogate Directed Employers via an Intermediary Services Organization *(Revenue Code 075 and 080)*

3. Adult Day Providers *(Revenue Code 084)*

4. Enhanced Residential Care Providers *(Revenue Code 074)*

D. Approved Activities

Respite Care Services may include the following approved activities:

1. Personal Care

2. Supervision

3. Socialization

E. Limitations

1. Respite Care Services as defined in this section are limited to participants approved by DAIL for services in the Home-Based setting.

2. Respite Care Services are limited to participants who have identified an unpaid caregiver who will benefit from respite.

3. Respite Care Services are limited to a maximum of 720 hours per calendar year in combination with Companion Services.

4. Respite Care Services provided in an Enhanced Residential Care setting must be utilized in 24/hour blocks.

5. Respite Care workers 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).*

6. Respite Care workers 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*).

7. Respite Care Workers 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*).

8. A spouse or a civil union partner shall not be paid to provide respite care services.

9. A legal guardian, appointed by the probate court, shall not be paid to provide respite care services.

10. An unlicensed private home shall not be paid to provide respite services to the participant living in their home.

11. Respite Care Services shall not be provided to a participant while out of the state of Vermont for more than 7 consecutive days.

12. Participant or Surrogate-Directed employees must be 18 years of age or older.

13. A surrogate employer shall not be paid to provide Respite Care Services.

14. Respite Care Services do not include the cost of room and board except when provided as part of respite care furnished in a Nursing Facility setting.

15. CFC shall not be used to provide Respite Care Services that are otherwise being purchased privately or paid for through another funding source.

16. CFC 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. A Respite Care employee shall not require the participant to pay privately for services already available through the CFC program.

SECTION IV. 5. Companion Services

A. Definition

"Companion Services" include supervision and socialization to individuals, who are unable to care for themselves. This specific Companion Service applies to people living in the home-based setting and is reimbursed at an hourly rate.

Note: Companion services in an Adult Family Care home setting is covered under the Adult Family Care service standards (Section IV.11).

B. Companion Standards

Companion Services providers who manage and supervise companion employees must be authorized to provide Choices for Care (CFC) services by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations

2. Participant and Surrogate-Directed Employer Responsibilities (Participant/Surrogate Employers only) as outlined in the Employer Handbook.

3. CFC Universal Provider Qualifications and Standards (*Section III*.)

4. CFC Services Principles (*Section IV. B*.)

C. Provider Types

The following provider types are approved to provide Companion Services when authorized by DAIL and identified on the individuals Service Plan:

1. Home Health Agencies *(as defined by State statute) (Revenue Code 073)*

2. Employees of Certified Participant or Surrogate Directed Employers via an Intermediary Services Organization *(Revenue Code 075 and 080)*

3. Vermont Senior Companion Program

D. Approved Activities

1. Limited Personal Care or Household Tasks

2. Supervision

3. Socialization

E. Limitations

1. Companion Services as defined in this section are limited to individuals approved by DAIL for services in the Home-Based setting.

2. Companion Services are limited to a maximum of 720 hours per calendar year in combination with Respite Care Services.

3. Assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) shall be limited by the skills and abilities of employees providing companion services, as determined by the provider.

4. Companion workers 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*).

5. Companion workers 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*).

6. Companion workers 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*).

7. A spouse or a civil union partner shall not be paid to provide companion care services.

8. A legal guardian, appointed by probate court, shall not be paid to provide companion care services.

9. Companion Services shall not be provided to a participant while out of the state of Vermont for more than 7 consecutive days.

10. Participant or Surrogate-Directed employees must be 18 years of age or older.

11. A surrogate employer shall not be paid to provide Companion Services.

12. CFC shall not be used to provide Companion Services that are otherwise being purchased privately or paid for through another funding source.

13. CFC services shall not contribute to the cost of the participant's room and board in a shared living arrangement (except in a nursing facility).

14. An unlicensed private home shall not provide or be paid to arrange for, care to more than two unrelated people in their home, regardless of the source of payment. (*Refer*

to the Residential Care Home Licensing Regulations for details http://www.dlp.vermont.gov/regs.)

15. A companion care employee shall not require the participant to pay privately for services already available through the CFC program.

SECTION IV. 6. Assistive Devices & Home Modifications

A. Definition

1. An "Assistive Device" is defined as an item, whether acquired commercially or off the shelf, which is used to increase, maintain, or improve functional capabilities. Such devices are intended to benefit the individual's identified goals for maintaining their health, safety, wellbeing and independence at home.

2. A "Home Modification" is defined as a physical adaptation to the home which is necessary to ensure the health, safety, wellbeing, accessibility and independence of the individual in the home. The adaptation may include, but is not limited to ramps, door widening, grab-bars and modification of bathroom facilities, etc. for accessibility.

3. "Assistive Technology" is defined as any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve functional abilities. Assistive technology devices required by individuals with disabilities include hardware and software as well as stand-alone devices.

B. Service Standards

Assistive Devices and Home Modifications must comply with the following:

1. All applicable medical and manufacturing standards.

2. All applicable State and local building codes.

3. All applicable Federal and State ADA Standards for building design.

C. Provider Types

The following Case Management provider types are approved to bill for Assistive Devices and Home Modifications:

1. Area Agencies on Aging

2. Home Health Agencies *(as defined by State statue)*

D. Procedure

All individuals receiving services in a home-based option (excludes AFC) are allowed to use assistive device and home modification funds, up to the current rate on file per calendar year. Through the process of person-centered planning, case managers shall work with the individual to identify the required assistive device, home modifications or assistive technology (AD/HM/AT) that will continue to benefit the individual's goals for maintaining their health, safety, wellbeing and independence at home. The Case Manager will then arrange for the purchase and payment of the AD/HM/AT that meets the needs/goals of the individual and the service definitions.

Prior to purchasing an item with AD/HM funds the Case Manager shall:

1. Ensure the item **meets the definition** of an assistive device, home modification or assistive technology.

2. Ensure the assistive device, home modifications and assistive technology are not otherwise available to the individual through Medicare, Medicaid, other insurance or other sources of funding. The case manager must check for insurance coverage **first** and document this step has been completed in the case notes.

3. Ensure when necessary, qualified consultants (such as Physical Therapists, Occupational Therapists or others) have been consulted to assess for and properly identify the appropriate devices or home modifications to meet the individual needs.

4. Ensure that home modifications are done by individuals/companies that work in accordance with the Federal/State ADA standards for accessible design and State and local building codes.

5. Ensure clear documentation in the case management notes that the AD/HM/AT will meet the individual's goal for maintaining or improving their health, safety, wellbeing and independence at home.

6. Ensure clear documentation in the case management notes of the outcome of how the AD/HM has met the individual's goal.

7. Send the individual a denial letter with DAIL appeal rights when it is determined that an assistive device, home modification or assistive technology purchase is not able to be purchased because it does not meet the definition or support the individual's goals.

E. Limitations on Assistive Devices and Home Modifications

1. Expenditures for assistive devices, home modifications and assistive technology are not to exceed the rate on file per calendar year.

2. Only assistive devices, assistive technology and home modifications that are not covered by Medicare, Medicaid, other insurance or other sources of funding can be purchased.

3. Funds may not be used to purchase assistive devices, assistive technology or home modifications that are not of direct benefit to the individual's identified goals/needs, health, wellbeing, safety, accessibility and independence at home.

4. Assistive Technology does not include a medical device that is surgically implanted, or the replacement of such device.

5. Funds may never be used to purchase any items that are illegal.

6. Funds may not be used to purchase Assistive devices and home modification in an Adult Family Care home setting.

7. All purchases are subject to quality review.

SECTION IV. 7. Personal Emergency Response System (PERS)

A. Definition

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

Note: PERS in an Adult Family Care home setting is covered under the Adult Family Care service standards (Section IV.11).

B. Approved Providers

PERS providers must be authorized to provide Choices for Care (CFC) services by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All legal requirements set by the Federal Communication Commission

2. Equipment must meet the Underwriters Laboratories, Inc. (UL) standards for home health care signaling equipment

3. CFC Universal Provider Qualifications and Standards (*Section III.*)

4. CFC Services (*Section IV.*).

C. Provider Types

The following provider type is approved to provide PERS when authorized by DAIL and identified on the individuals Service Plan:

- DAIL authorized Personal Emergency Response Providers *(Revenue Codes 082 & 083)*

D. Approved Activities

PERS services shall include the following approved, reimbursable activities when PERS is identified on the individual's Service Plan:

1. Installation and maintenance of PERS equipment in the participant's home by appropriately trained staff.

2. PERS equipment which provides the participant (or caregiver) with the ability to reliably activate an immediate emergency signal to the surveillance/response center.

3. PERS equipment which has an uninterruptible power source.

4. PERS equipment which is appropriate to the individual's cognitive, physical, and medical condition.

5. Information and training to the participant (and caregivers, as necessary) regarding the use of the PERS equipment.

6. Continuous surveillance of signaling equipment for activated signals by the surveillance/response center 24 hours per day, 365 days per year.

7. Scheduled testing of all in-home equipment at least every 90 days to ensure that equipment is functional.

8. A telephone line monitor that ensures that telephone connections are maintained between the PERS equipment in the home and the surveillance/response center.

9. A direct response to the participant within 60 seconds by surveillance/response center professional staff who has been trained in emergency response and who use an established response protocol over the PERS equipment and/or the telephone.

10. An emergency telephone communication from the surveillance/response center in accordance with an established protocol to a local response network including friends, neighbors, police, fire, and/or ambulance, depending on the nature of the emergency.

11. A response by trained professional staff who has been trained in emergency response and who use response protocols for each participant.

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12. Detailed documentation of responses to all activated signals.

13. Detailed technical and operations manuals which describe PERS elements, including PERS equipment specifications, installation, functioning, and testing, staff training requirements, emergency response protocols, and record keeping and reporting procedures.

14. Optional equipment upgrades, as determined by the PERS provider, and provided within the current maximum rate. (e.g. medication reminder)

E. Limitations

1. PERS services as defined in this section are limited to individuals approved by DAIL for services in the Home-Based setting.

2. PERS services are limited to a maximum of twelve (12) months of service per calendar year.

3. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time.

4. PERS services are limited to individuals who are able to effectively utilize PERS equipment.

SECTION IV. 8. Enhanced Residential Care (ERC)

A. Definition

"Enhanced Residential Care" (ERC) is a daily, bundled package of services provided to individuals residing in an approved Vermont Licensed Level III Residential Care Home (RCH), Assisted Living Residence (ALR) or Homes for the Terminally Ill (HTI).

B. ERC Standards

ERC providers shall be authorized to provide Choices for Care (CFC) services by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations (https://dlp.vermont.gov/survey-cert/facility-regs)

2. CFC Universal Provider Qualifications and Standards (Section III.)

3. CFC Services (Section IV.)

4. ERC providers shall have current licenses issued by DAIL.

5. ERC providers shall have a satisfactory current inspection from the Department of Public Safety, Division of Fire Safety (DFS) and have been approved for participation in the program with respect to Life Safety issues by the DFS.

C. Provider Types

The following provider types are approved to provide ERC Services when authorized by DAIL and identified on the individuals Service Plan:

1. Vermont Licensed Level III Residential Care Homes *(Revenue Codes 090, 092, 093, 094)*

2. Vermont Licensed Assisted Living Residences (ALR) *(Revenue Codes 090, 092, 093, 094)*

3. Vermont Licensed Homes for the Terminally Ill (HTI) (*Revenue Code 090)*

D. Approved Activities

Enhanced Residential Care (ERC) Services includes the following approved, activities, reimbursable under the daily ERC rate:

1. Nursing Overview: Assessment, health monitoring, and routine nursing care shall be provided or supervised by a Licensed Registered Nurse, available at least one (1) hour per week per ERC resident as needed.

2. Personal Care Service (ADL): Assistance with meals, movement, bathing, dressing, transferring, personal hygiene, grooming and toileting shall be provided and available for at least two (2) hours per day per ERC resident as needed.

3. Medication Management: The process of assisting residents to self-administer their medications or administering medications, under the supervision and delegation by the RN.

4. Recreation Activities: Social or recreational activities, either in a group setting or individually, must be offered daily. Activities may be in the home or community.

5. 24-Hour On-Site Supervision: ERC staff must be on duty seven (7) days a week, twenty-four (24) hours a day.

6. Laundry Services: Laundry services shall be provided as well as the opportunity to launder one's own clothing if desired.

7. Household Services: Bed-making and household cleaning shall be provided.

8. Documentation: ERC providers shall maintain a resident record on each resident served under the ERC program according to the Licensing regulations. The record shall include at a minimum:
   a. the current DAIL Service Plan,
   b. resident service plan,
   c. request and approval of Level of Care (LOC) variance *(Level III RCH only)*,
   d. health records,
   e. a report/incident log,
   f. current Resident Assessment (RA), and
   g. activity assessment and plan.

9. Case Management: Level III RCH/ALR's providing ERC services will provide person-centered case management services according to the residential care home and Medicaid ACCS services regulations. The home will assist with gaining access to needed medical, social or other services which may include consultation with providers and support person(s).

10. Assistive Community Care Services (ACCS): Level III RCH/ALR's can also bill ACCS when an individual receives ERC services. ACCS services include case management, personal care, nursing assessment, medication assistance, onsite assistive therapy and restorative nursing.

E. Limitations

1. ERC Services as defined in this section are limited to individuals approved by DAIL for CFC in the Enhanced Residential Care setting.

2. An individual shall not receive Medicaid-funded services from Adult Day centers while receiving CFC ERC services.

3. CFC reimbursement for ERC services does not include room and board. The individual is responsible for payment of room and board. The ERC must abide by the DAIL room & board guidelines.

4. ERC providers shall not bill Medicaid for individuals who are absent from the home. (*Refer to Section V.10*)

2. Personal Care Service (ADL): Assistance with meals, movement, bathing, dressing, transferring, personal hygiene, grooming and toileting shall be provided and available for at least two (2) hours per day per ERC resident as needed.

3. Medication Management: The process of assisting residents to self-administer their medications or administering medications, under the supervision and delegation by the RN.

4. Recreation Activities: Social or recreational activities, either in a group setting or individually, must be offered daily. Activities may be in the home or community.

5. 24-Hour On-Site Supervision: ERC staff must be on duty seven (7) days a week, twenty-four (24) hours a day.

6. Laundry Services: Laundry services shall be provided as well as the opportunity to launder ones own clothing if desired.

7. Household Services: Bed making and household cleaning shall be provided.

8. Documentation: ERC providers shall maintain a resident record on each resident served under the ERC program according to the Licensing regulations. The record shall include at a minimum:
   a. the current DAIL Service Plan,
   b. resident service plan,
   c. request and approval of Level of Care (LOC) variance *(Level III RCH only)*,
   d. health records,
   e. a report/incident log,
   f. current Resident Assessment (RA), and
   g. activity assessment and plan.

9. Case Management: Level III RCH/ALR's providing ERC services will provide person-centered case management services according to the residential care home and Medicaid ACCS services regulations. The home will assist with gaining access to needed medical, social or other services which may include consultation with providers and support person(s).

10. Assistive Community Care Services (ACCS): Level III RCH/ALR's can also bill ACCS when an individual receives ERC services. ACCS services include case management, personal care, nursing assessment, medication assistance, onsite assistive therapy and restorative nursing.

E. Limitations

1. ERC Services as defined in this section are limited to individuals approved by DAIL for CFC in the Enhanced Residential Care setting.

2. An individual shall not receive Medicaid-funded services from Adult Day centers while receiving CFC ERC services.

3. CFC reimbursement for ERC services does not include room and board. The individual is responsible for payment of room and board. The ERC must abide by the DAIL room & board guidelines.

4. ERC providers shall not bill Medicaid for individuals who are absent from the home. (*Refer to Section V.10*)

SECTION IV.9. Nursing Facility (NF) Services

A. Definition

"Nursing Facility" (NF) services are a daily, bundled package of services provided to individuals residing in an approved Vermont Licensed Nursing Facility.

B. Nursing Facility Standards

NF providers shall be authorized by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations http://www.dlp.vermont.gov/regs

2. CFC Universal Provider Qualifications and Standards (Section III.)

3. CFC Services (Section IV.)

4. NF providers shall have current licenses issued by the Department of Disabilities, Aging and Independent Living.

C. Provider Types

The following provider types are approved to provide Nursing Facility Services when authorized by DAIL:

- Vermont Licensed, Medicare Certified and Medicaid approved Nursing Facilities *(revenue codes 120, 128, 130, 169, 182 & 185)*

D. Approved Activities

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

1. Room and Board

2. Skilled Nursing

3. Personal Care

4. Medication Management and pharmacy services

5. Social Worker Services & Recreation Activities

6. 24-Hour On-Site Nursing Supervision

7. Laundry Services

8. Housekeeping Services

9. Transportation Services

10. Physical Therapy, Occupational Therapy and Speech Therapy

11. Nutritional and Dietary Services

12. Maintenance of Resident Clinical Records.

E. Limitations

1. NF services as defined in this section are limited to individuals approved by DAIL for CFC in the Nursing Facility setting.

2. A participant may not receive Medicaid-funded services from Adult Day centers, while receiving CFC services in the nursing facility setting.

3. NF providers may not bill for individuals who are absent from the facility, unless the absence qualifies under the current "Leave of Absence" rules (7604.1 & 7604.2).

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. <u>Room and board for the participant:</u> 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. <u>Gambling, alcohol and recreational drugs, both legal and illegal</u>.

    d. <u>Items covered by other programs</u>: 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.

SECTION IV.11 Adult Family Care

A. Definition

Adult Family Care is a Choices for Care (CFC) 24-hour home and community-based option in which participants live-in and receive services from an Adult Family Care (AFC) Home Provider who is contracted by an Authorized Agency. Also known as "Shared Living", AFC is provided in the residence of an unlicensed Home Provider who provides the care and support to no more than two individuals unrelated to the Home Provider.

B. AFC Standards

AFC providers must be authorized by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations
2. Federal Home and Community Based Setting (HCBS) Requirements
3. Vermont Housing Safety & Inspection Process Protocol
4. AFC Disclosure of Information Procedures (Section V.15 of this manual.)
5. CFC Universal Provider Qualifications and Standards (Section III. of this manual.)
6. Internal Revenue Service (IRS) code Title 26 Section 131 (difficulty of care payment law)
7. DAIL Critical Incident Policy
8. Department of Vermont Health Access (DVHA) Medicaid General Provider Agreement
9. DAIL Room and Board Policy
10. DAIL Background Check Policy

C. Provider Types

The following provider types are approved to provide and bill for Adult Family Care services when authorized by DAIL and identified on the individuals Service Authorization:

- Authorized Agencies (AA) (Revenue Code 086)

D. Authorized Agency Responsibilities

An Authorized Agency (AA) is an agency authorized by Department of Disabilities, Aging and Independent Living (DAIL) to provide Adult Family Care (AFC) through the Choices for Care Program.

Authorized Agency responsibilities include:

1. 24-hour on-call Backup: Provide twenty-four hour on-call back-up and support to paid caregivers and natural supports.

2. Care Planning: Identify the goals, strengths and needs of the participant through a person-centered process. Person-centered planning shall be timely and occur at times and locations of convenience to the individual. A plan shall be developed identifying the services and supports to be delivered to meet the individual's needs and goals. The person-centered plan shall reflect a live-in setting that is chosen by the individual in which to reside.

3. Modifications: "Modifications" are any individual-specific exceptions to the person-centered planning and HCBS setting requirements. Modifications to the HCBS settings and person-centered planning requirements must be documented and include the following:
   (a) Identify a specific and individualized assessed need for modification
   (b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan
   (c) Document less intrusive methods of meeting the need that have been tried but did not work
   (d) Include a clear description of the condition that is directly proportionate to the specific assessed need
   (e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification
   (f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
   (g) Include informed consent of the individual
   (h) Include an assurance that interventions and supports will cause no harm to the individual
   (i) All modifications will be reviewed with service coordinators on a periodic basis.

4. Conflict of Interest Mitigation: Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of HCBS services must maintain a conflict of interest policy that is in line with the standards set by the Centers for

Medicare and Medicaid in regulation. At a minimum, the entity (service coordinator) developing the HCBS person-centered plan may not be any of the following:

a) Related by blood or marriage to the individual or to the paid caregivers of the individual
b) Financially responsible for the individual
c) Empowered to make financial or health-related decision on behalf of the individual
d) Holding financial interest in an entity that is paid to provide care for the individual
e) Providers of HCBS services or employed by a provider of HCBS services for the individual. (TBD – unless allowed by CMS & the State under certain circumstances)

5. Communication: Ensure timely communication and coordination with the participant and AFC home provider in the event of any changes in the individual's health, functional needs, preferences or wishes that require changes in the plan of care.

6. Complaints: Inform participants of the AA complaint policy, work to resolve complaints and provide all participants with Ombudsman brochure.

7. Contract: Identify and contract with Adult Family Care (AFC) Home providers.

8. Critical Incidents: Follow established Critical Incident Reporting Procedures.

9. Difficulty of Care Payment: As defined by the Internal Revenue Service (IRS) code Title 26 Section 131, AA will provide a difficulty of care payment (tax free stipend) to contracted AFC home providers.

10. Documentation:
Documentation, at a minimum must include the following:

a) 24- hour emergency back- up plan
b) Emergency fact sheet
c) AFC ILA, Tier Scoring Worksheet and AFC Service Plan
d) Comprehensive person-centered plan
e) Monthly home visits by the AFC coordinator
f) Accessibility and home safety inspections
g) A written contract and/or job description for all caregivers describing expectations, responsibilities and compensation
h) Back ground checks as specified in the DAIL background check policy
i) Pre-service training and annual ongoing training for paid workers including contracted home providers
j) Room and board agreement and/or contract for care
k) Quality management activities, including but not limited to critical incident reports and grievances and the resolution
l) Advance Directives, Power of Attorney or Guardianship order
m) Applications for other services or public benefits and the

n) Ongoing service coordination activities
o) Coordination of documentation and communication with the authorized agency
p) Agreement for Live-in Care
q) AFC AA Referral Form to be used and forward to chosen AAs.

11. Home Inspection: Arrange for home safety and accessibility inspections according to the Vermont Housing Safety & Accessibility Inspection Process Protocol.

12. Legal Representatives: Maintain a copy of and comply with Advance Directives, Power of Attorney and Guardianship authorities.

13. Live-In Agreement: Ensure the AFC Home Live-In Agreement exists and retain a copy of current agreement in participant's file.

14. Monitoring: Ongoing review of the individual's health and wellbeing, functional needs, service utilization, goals and outcomes. See Section V.4 Monitoring Procedures for minimum monitoring requirements.

15. Payment of Services: Submit timely claims to DXC and process on-time payments to the AFC Home provider and other contracted services per the participant's person-centered plan and service authorization.

16. Pre-Transition Assessment, Planning & Matching: Complete the initial AFC assessment and facilitate AFC Home provider matching process, including the inclusion of the participant choice of home providers and selection of caregivers. See "Limitations" for billing details.

17. Quality Reviews: Participation with DAIL in quality management reviews.

18. Respite: Ensure AFC Home provider receives adequate respite.

19. Service Coordination: The process by which services are obtained for the individual through coordination with multiple resources and providers, including access to community resources and transportation. (See Section V.4 -Subsection C. Adult Family Care for monitoring responsibilities)

20. Staffing: Ensure that staff is trained and background checks (DAIL Background Check Policy) are in place per the participant's person-centered plan.

21. Training: Ensure that AFC home provider and other support staff receives orientation and pre-service training to meet the needs of the participant. Ensure that the AFC home provider participates in training to obtain (6) hours of continuing education annually.

22. Transitions: Assist participants with moving from the AFC home to a new CFC option.

E. AFC Home Provider Responsibilities

An AFC Home Provider (also known as a Shared Living Provider) provides individualized supports in an environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity for up to two individuals. The home must be contracted with an Authorized Agency (AA). In addition, the home provider will receive a tax-free stipend called a "Difficulty of Care" payment.

The home provider shall always ensure that the participant's environment promotes a positive domestic living experience and assist the participant in realizing his/her maximum individual potential for independence.

A parent, legal guardian, representative payee or spouse of the individual receiving AFC services is not eligible to be an AFC home provider.

The home providers shall:

1. Be 21 years or older,
2. Own or rent the shared living residence where AFC services are or will be provided to the Choices for Care participant(s),
3. Reside in the shared living residence under the same roof with the Choices for Care participant(s),
4. Successfully pass the background checks required by DAIL.
5. Participate and comply with required home Safety and Accessibility standards.
6. Maintain a Live-In Agreement with the participant in accordance with the DAIL Room & Board standards.
7. Agree to contract with an AA and receive a Difficulty of Care payment.
8. Provide or arrange for care and supervision for the participant 24 hours/day as described in the AFC ILA and person-centered plan, including:
    a) personal care (activities of daily living);
    b) household tasks (instrumental activities of daily living);
    c) community access (e.g. shopping and use of community facilities);
    d) leisure time activities chosen by the participant allowing freedom and support to control his/her own schedule; and
    e) transportation to a reasonable number of community functions (directed by participant interest).
9. Provide access to food, which includes a complete and balanced diet as determined by the participant's needs and desires.
10. Provide entrance doors that are lockable by the participant, with only appropriate staff having keys to the doors.
11. Allow the participant the freedom and support to furnish and decorate his/her sleeping or living unit within the boundaries of the lease or other agreements.
12. Maintain regular visits or contacts with the participant during hospitalizations, as appropriate to medical and social needs and as determined by the AFC Service Coordinator.
13. Participate in CFC reassessments.

14. Comply with Critical Incident Reporting and mandated reporting of abuse, neglect or exploitation to Adult Protective Services.
15. Maintain records and recommendations per AFC home provider contract for services.
16. Allow home visits by DAIL staff, Ombudsman, AA staff and other visitors of the participant's choosing at any time, as determined by the participant or legal representatives.
17. Communicate with the participant, legal representatives, and AA coordinator.
18. Participate in orientation and trainings.
19. Obtain six (6) hours of continuing education annually.

F. Safety and Accessibility Inspection

Each Adult Family Care home will receive a Safety and Assessibility inspection according to the Vermont Housing Safety and Accessability Inspection Process Protocol.

G. Critical Incident Reporting

Critical Incident reports are essential methods of documenting, evaluating and monitoring certain **serious or severe** occurrences, and ensuring that the necessary people receive the information. All AFC participants are subject to DAIL Critical Incident Reporting process and mandated reporting for Adult Protective Services. Refer to Section V.14. Critical Incident Reporting for details.

H. Disclosure of Information for AFC Home Providers and Respite Workers

Disclosure of Information (DOI) process is intended to assure that Choices for Care Adult Family Care Home providers and Adult Family Care respite workers receive relevant information, so they can make an informed decision whether to agree to provide care in their own home to Choices for Care Adult Family Care participant. The DOI form shall include relevant information about a person's status and history of violent behaviors, any potential predictors of violent behavior and any medications they are taking. The information may only be disclosed with the participant or guardian's authorization. Refer to Section V.15. Adult Family Care Disclosure of Information Procedures for more information.

I. AFC Limitations

1. AFC payment is limited to the AFC Tier rate as identified on the Service Authorization.

2. Home providers must be 21 years of age or older.

3. Home providers shall not be the parent, stepparent, adoptive parent, domestic partner, spouse, legal guardian, or representative payee of the individual they are paid to support.

4. Home Providers shall not care for more than two individuals in the home that are unrelated to the Home Provider.

5. Full AFC Tier payment is effective the date the participant moves in with the AFC Home Provider.

6. The AA may bill up to $35/day for pre-transition assessment, planning and matching services for up to 60 non-consecutive days prior to the date of transition into the AFC home for eligible CFC participants. The eligible start for billing pre-transition services begins no earlier than the date the AA has notified the DAIL Long-Term Care Clinical Coordinator that the participant and AA have an agreement to start AFC services. (See Section V.10. Enrollment & Billing, for more information.)

7. The authorized AFC Tier rate is not billable when a participant is in another CFC setting including Enhanced Residential Care and nursing facility.

8. AFC Services may be billed at 94% of the daily AFC Tier rate, for up to 30 days, when the participant is in the hospital and continues to receive AFC services and supports during the hospital stay.

9. Participants residing in an AFC home are not eligible for external CFC case management services provided by a non-AA case management provider. If the participant wants to leave the AFC Home and transition to another CFC setting, it is the responsibility of the current AA to ensure a person-centered transition for the participant.

10. AFC home providers or 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).

11. AFC home providers or 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).

12. AFC home providers or 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).

13. The participant's legal guardian shall not be paid to provide AFC services to the participant.

14. AFC services shall not be provided to a participant who has left the state of VT for more than 7 consecutive days.

15. CFC shall not pay for home maintenance and repairs.

16. CFC shall not pay for Room and Board.

17. CFC shall not pay for any service already paid to the home provider as described in the Live-In Care Agreement or in a separate, private arrangement (e.g. "Contract for Care")

18. CFC shall not pay for services covered by other health insurance such as Medicare, Medicaid, VA or private insurance.

J. AFC Participant's Rights and Responsibilities

In addition to the Choices for Care Participant's Rights (*See Section VIII. Choices for Care Participant Rights and Responsibilities)*, Adult Family Care Participant's rights also include:

1. A participant shall have access to food and will be provided with basic utilities to include electricity, heat, water, sewer, trash removal and access to basic telephone services. Any participant may also, at the participant's own expense, maintain a personal telephone in his or her own room.

2. Participants have the right to retain personal clothing and possessions as space permits and exercise the right to furnish/decorate his/her own living unit, unless to do so would infringe on the rights of others or would create a fire or safety hazard.

3. Participants have a right to privacy, to include lockable doors with only appropriate staff having keys to doors.

4. Participants shall be free to come and go from the home and exercise the right to control his/her own schedule and activities to the extent they are able to independently or with the help of others.

5. Participants shall not be required to perform work for the Home Provider. If a participant chooses to perform specific tasks for the Home Provider, the participant shall receive reasonable compensation which shall be specified in a written agreement with the participant.

6. Participants may have visitors (scheduled and unscheduled) from friends, family and case managers during times indicated in the live-in agreement. Participants may accept or refuse their visitors.

7. Each participant may send and receive personal mail unopened.

8. Participants have the right to voice a complaint without interference, coercion or reprisal. The complaint procedure shall follow CFC Manual Section V.13. A participant filing a complaint will be made aware of the Office of the Long-Term Care Ombudsman and the designated Vermont Protection and Advocacy Organization as an

alternative.

9. Participants have the right to manage their own personal finances. The participant, legal representative or guardian may request in writing that the home provider manage the participant's finances. The home provider shall keep a record of all transactions and make the record available, upon request, to the participant or legal representative, and shall provide the participant with an accounting of all transactions at least quarterly. Participant funds must be kept separate from other accounts or funds of the home.

10. Participants who request a voluntary move from the home shall:

    a. Be allowed to participate in the decision-making process of the home concerning the selection of an alternative placement
    b. Provide at least a thirty (30) day notice of a pending move to the home provider

11. Participants subject to an involuntary move from the home shall:

    a. Receive a thirty (30) day notice of a pending move if it is determined that the home provider is no longer able to meet the participants care needs
    b. Be allowed to participate in the decision-making process of the Authorized Agency concerning the selection of a new home provider or other placement
    c. Receive a pending move notice on or after thirty-one (31) consecutive days of hospitalization.

14. Participants have the right to refuse care to the extent allowed by law. The home must fully inform the participant of the consequences of refusing care, which may include a negotiated risk contract. If the participant makes a fully informed decision to refuse care, the home must respect that decision. If the refusal of care will result in a participant's needs increasing beyond what the home is able to provide or will result in the home being in violation of AFC requirements, the home may issue the participant a thirty (30) day notice of move.

15. Participants have the right to return to the home after a hospital stay, provided the home is able to meet the participants care needs and provided, the participants welfare, or that of other participants will not be adversely affected.

16. Participants have the right to formulate advance directives as provided by state law and to have the home follow the participants' wishes.

17. Participants have the right to be away from the home for voluntary leaves, unless a legally appointed guardian directs the home otherwise. Participants have the right to make decisions about such voluntary leaves without influence from the home.

These participants' rights shall not limit, modify, abridge or reduce in any way any rights that a participant otherwise enjoys as a human being and citizen.

K. AFC Participant Responsibilities

As an AFC Program participant, you are responsible to:

1. Work with your service coordinator and team to develop/revise your person-centered plan and care plan as needed.

2. Inform your service coordinator and team when you care or goals change.

3. Provide, to the best of your knowledge, complete and accurate medical history including all prescribed and over the counter medications you are taking and understand the risk(s) associated with your decisions about care.

4. Ask questions when you do not understand your services.

5. Not participate in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the CFC program may be jeopardized.

6. Report any significant changes in your medical condition, circumstances, informal supports and formal supports to the members of your care team (case manager, service coordinator, service providers etc.).

7. Provide accurate information related to your coverage under Medicaid, including any notices from the Department of Vermont Health Access regarding your Medicaid, Medicare or other medically-related insurance programs to your service providers.

8. Notify your service providers as soon as possible if a scheduled visit needs to be rescheduled or changed.

9. Notify appropriate person(s) should any problems occur or if you are dissatisfied with the services that are provided.

10. Treat your service providers with consideration, dignity and respect.

L. Shared Living Agreement

The Shared Living Agreement is a written and signed document between the participant and Home Provider that outlines the room and board amount, other allowable fees, the participants' rights and the Home Provider obligations. All AFC participants must have a Shared Living Agreement with a copy maintained with the Authorized Agency. The Home Provider may use the optional template or create their own agreement as long as it contains all of the required information as outlined in the Shared Living Agreement Form and Instructions (CFC 808 Form).

The agreement must be completed upon move in with the home provider and renewed only as conditions of the living arrangement change.

SECTION V. Procedures

The procedures section contains Choices for Care (CFC) procedures for the following:

1. Application & Eligibility Determination
2. Waiting List
3. Initial Assessment & Reassessment
4. Monitoring
5. Changes and Start Dates
6. Initiating Services
7. Denials & Terminations
8. Notices, Variances & Appeals
9. Utilization Review
10. Enrollment &Billing
11. Informed Consent & Negotiated Risk
12. Medicare Advocacy Project (MAP)
13. Complaints
14. Critical Incident Reporting
15. AFC Disclosure of Information
16. 16. ICD – 10 Code Policy & Procedures

SECTION V.1. Application & Eligibility Determination Procedures

A. Choices for Care Applications

A Choices for Care application is required for any person who needs Vermont (VT) Medicaid coverage for long-term services and supports and believes they may meet the clinical and financial eligibility standards outlined in ***Section II. Eligibility***. An application is not required for people in need of medical care or short-term rehabilitation services covered by insurance such a Medicare, Vermont Medicaid, Veteran's benefits (VA) or private insurance. ***People must refer to their specific insurance coverage standards for medical care and rehabilitation coverage at home or in a nursing facility.***

1. Consistent with Act 123, hospitals and nursing facilities staff shall provide information on how to apply to Choices for Care to individuals in need of assistance to pay for long-term services and supports, at the time of admission or as soon as possible following admission.
    a. Facility staff shall assist those individuals who want to apply for Choices for Care waiver services, regardless of what setting they may be interested in (home-based, nursing facility, enhanced residential care or Adult Family Care).
    b. Facility staff shall complete assessments, as needed according to their internal protocols.
    c. DAIL staff shall provide hospital and nursing facilities with information regarding long-term services and supports options for individuals whom facility staff believes could benefit from receiving the information.
    d. Facility staff shall send the completed Choices for Care application on behalf of the individual, to the DCF-ESD Application and Document Processing Center in a timely manner.

2. Individuals who wish to enroll in the Choices for Care shall complete obtain an application obtained by calling 1-800-479-6151 or online at http://dcf.vermont.gov/esd/ltc_medicaid. Application are submitted to the Application and Document Processing Center (ADPC) of the Economic Services Division (ESD) of the Department for Children and Families (DCF):
   DCF – Economic Services Division.
   Application and Document Processing Center
   103 South Main Street
   Waterbury, VT 05671-1500

3. Individuals in a nursing facility (or hospital swing bed) who require continued coverage beyond their private resources or insurance benefit coverage (e.g. Medicare, Vermont Medicaid, VA private insurance) may apply for Choices for Care for assistance to pay for continued coverage. The DAIL LTCCC nurse shall visit the individual in the facility setting as necessary to assess the individual, determine clinical eligibility, and discuss care/support options. ***Continued payment to the nursing facility (or hospital swing bed) will only occur after the individual has been found clinically and financially eligible for Choices for Care under the long-term care Medicaid rules.***

4. When an individual's circumstances present a clear emergency, and DAIL staff is unavailable, he or she may be admitted to services without prior approval from the Department. Under these circumstances, an application shall be completed prior to admission to services (if possible) and the Department shall complete a retrospective review to determine eligibility. If individuals are determined to be ineligible, the Department shall not be responsible for the cost of services provided to the individual.

B. Initial Choices for Care Screening

1. When DCF-ESD receives the 202 LTC Choices for Care application a copy will be forwarded electronically to DAIL staff.

2. When DAIL staff receives the Choices for Care application from DCF-ESD, DAIL staff will contact the individual and/or referral source to gather additional information as needed and to schedule a clinical eligibility assessment. DAIL staff will contact the individual and/or referral source within three (3) working days.

3. Department staff may utilize existing assessment information to assist in determining clinical eligibility.

4. When DAIL LTCCC nurses receive a Choices for Care application for individuals in the hospital who are dependent upon Choices for Care coverage for their discharge, he or she shall make reasonable efforts to assess the individual and explain options, prior to discharge. If a face-to-face visit is not possible prior to discharge, DAIL LTCCC nurses shall make arrangements to see the individual as soon as possible following discharge.

C. Clinical Assessment

DAIL staff will determine the clinical eligibility (Highest or High Needs Group) from gathering information during a face-to-face assessment. **DAIL staff** will complete an assessment using the "Choices for Care Clinical Assessment" (CFC 802) to determine clinical eligibility. DAIL shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application, unless the application is put "on hold" status. (E.g. the individual has not decided on the setting in which to receive services, remains in the hospital).

1. Highest Needs Group: All individuals who apply and meet both the clinical criteria for Highest Need and the financial criteria for Long-term Care (LTC) Medicaid services shall be enrolled in the program. Active program participants who meet the Highest Needs group clinical criteria at reassessment shall not be terminated from services, provided that they continue to meet all other eligibility criteria.

2. High Needs Group: Enrollment in the High Needs group shall be limited by the availability of funds. Individuals who apply and meet both the clinical criteria for the High Needs group and the financial criteria for Long-term Care (LTC) Medicaid services may be enrolled in the program.

a. If funds are unavailable, the names of eligible applicants shall be put on a waiting list. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:

i. Unmet needs for ADL assistance;
ii. Unmet needs for IADL assistance;
iii. Behavioral symptoms;
iv. Cognitive functioning;
v. Formal support services;
vi. Informal supports;
vii. Date of application;
viii. Need for admission to or continued stay in a nursing facility;
ix. Other risk factors, including evidence of emergency need; and
x. Priority score.

b. DAIL staff shall send a written notice to individuals whose names are placed on a waiting list, which shall include information about how the waiting list operates.

c. When an individual's circumstances present a clear emergency, and DAIL staff is unavailable, the individual may be admitted to services without prior approval from the Department. Under these circumstances, DAIL staff shall complete a retrospective assessment/review to determine eligibility. Individuals who are determined not to be eligible may be responsible for the costs of services that have been received.

d. All active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.

e. DAIL staff shall review the status of eligible applicants whose names have been on the waiting list for sixty (60) days to ensure that the applicant's needs have not changed.

f. Any eligible applicant whose name has been on the waiting list for 60 days or more shall be given priority for enrollment over eligible applicants with similar needs whose names have been on the waiting list for a shorter amount of time.

D. Financial Assessment

The Choices for Care Long-Term Care Medicaid application (202 LTC) initiates both the clinical

and the financial eligibility determination process.

E. Long-Term Care Options

DAIL staff shall discuss CFC options as part of the application and assessment process. DAIL staff will ensure that options brochures and information will be made readily available as needed.

F. Notifications

If the applicant is found clinically eligible for the Highest Needs group, or the High Needs group with funds available, DAIL staff will send a Clinical Certification (CFC 803) notice to DCF, case management agency, Transition II or Authorized Agency (HB setting), the Enhanced Residential Care provider (ERC/community setting) and the Nursing Facility provider. DCF staff will then complete the Long-Term Care Medicaid financial eligibility process. If the applicant is found clinically ineligible, DAIL staff shall send a written notice to the applicant with appeal rights and will notify DCF.

G. Adult Family Care Tier

For individuals choosing the AFC setting, DAIL staff will send a referral to the participants Case Management (CM) agency of choice. The CM will complete the AFC ILA assessment and review Authorized Agency (AA) options. When the participant has chosen an AA, the CM will forward a copy of the AFC ILA to the AA as a referral. The CM will send the AFC ILA and tier score to DAIL. DAIL staff will complete Utilization Review (UR) and then inform the CM agency of the tier. The CM will then inform the participants chosen AA of the tier. If the AA is able to serve the participant, the AA will begin the home provider matching process. When a home provider match is found, the CM will complete the AFC service plan with the tier and will obtain signatures from the participant and/or authorized representative, the AA and the home provider. The CM will send the service plan to DAIL staff for authorization. DAIL staff will authorize the service plan when DCF staff has notified DAIL that the participant is financially eligible for Long Term Care Medicaid.

H. Final Authorization

When financial eligibility is determined, DCF staff will notify DAIL, applicant and highest paid provider (if patient share due). If the applicant is found financially eligible, DAIL staff will authorize services (a Service Plan for home-based and ERC settings is required before DAIL may authorize services) and send notification to individual and providers. In the nursing home setting, the Notice of Decision from DCF- ESD is the authorization notification of eligibility.

I. Transitional Provision

All individuals who were being served under a preexisting 1915c Medicaid Waiver (Home-Based or Enhanced Residential Care) or who were receiving Medicaid nursing facility care at the time of the implementation of the Choices for Care waiver October 1, 2005, shall be enrolled in the Choices for

Care waiver and shall continue to receive services. Thereafter, these participants shall continue to be enrolled in Choices for Care if, at reassessment, they meet the eligibility criteria for the Highest Needs group, the High Needs group or the Guidelines for Nursing Home Eligibility adopted in April of 1997.

J. Continued Eligibility

1. Screening: DAIL staff will screen reassessment and forms for missing or incomplete information. DAIL staff will contact the case manager or individual to gather additional information, as needed.

2. Clinical Re-Assessment: DAIL staff will determine clinical eligibility (Highest Needs group or High Needs group) from assessment information submitted with the continued eligibility materials. A face-to-face review may be completed as necessary.

    a. Highest Needs Group: Active program participants who meet the Highest Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria.

    b. High Needs Group: Active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.

    c. Ineligible Participants: Active program participants who do not meet clinical eligibility criteria for any group shall be disenrolled and shall receive written notice of this decision with appeal rights.

3. Financial Eligibility: DCF staff shall be responsible for determining whether individuals remain eligible under Long-Term Care Medicaid financial eligibility criteria for the Highest Needs group or the High Needs group.

4. Final Authorization: DAIL staff shall authorize services and send written notice to the individual, the legal representative, and the provider(s). If the participant is found to be clinically ineligible, DAIL staff shall send a written notice with appeal rights. If the participant is found to be financially ineligible, DCF staff shall send written notice with appeal rights.

5. Time Limit: DAIL staff shall make a clinical eligibility determination within thirty (30) days of receiving the 202 LTC Choices for Care application.

K. Short-term Rehab in a Vermont Nursing Facility

A Choices for Care application is not required for people who have both Medicare and/or Vermont Medicaid coverage for short-term rehabilitation in a nursing facility. Medicare coverage rules may be found at ***http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf.*** Refer to the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*, for more details on Vermont Medicaid coverage.

Steps for authorizing Dual Medicare/VT Medicaid and VT Medicaid only covered short-term rehab stays:

1. **Referral**: The nursing facility receives a referral for short-term rehab.
2. **Choice**: The nursing facility verifies the person's choice to receive care in their facility.
3. **Insurance Verification**: Nursing facility verifies the person's Medicare and/or Medicaid insurance coverage. Malcolm phone system: **1-800-925-1706, out of state 802-878-7871**
4. **Clinical Verification, Dual Medicare/Medicaid Stays**: Medicare is always the primary payor for people with both Medicare and VT Medicaid coverage. VT Medicaid co-insurance coverage starts day 21 to day 100 of Medicare stay, following all Medicare standards, including a 3-day qualifying hospital stay. Medicare standards found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf
   NOTE: Medicare must be utilized before VT Medicaid when the person meets Medicare standards of coverage.
5. **Clinical Verification, Medicaid Only Stays**: If a person has no Medicare or private insurance coverage, VT Medicaid rehab benefit covers up to 30 days per episode/60 days per calendar year following the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays.*
   NOTE: Medicare and private insurance must be used before Medicaid only coverage.
6. **Admission to Nursing Facility**: After the nursing home verifies coverage, the nursing facility must notify DCF within 10 days of the admission using required DAIL form CFC 804C, and makes plans for admission, following all existing state and federal regulations.
7. **DCF Long Panel Dual Medicare/Medicaid Stays**: DCF verifies Medicare and VT Medicaid coverage based on the notification from the nursing facility. DCF enters a long panel in the ACCESS system using the Highest Need category. The start date is the 21st day after admission (the start of Medicaid co-insurance payments). The end date is the "last day of coverage" date reported by the nursing facility, up to day 100 of the Medicare covered stay. If the nursing facility does not report the end date on the admission notification, DCF enters a 30-day segment starting on day 21 and ending on day 50 of the Medicare admission. When the nursing facility submits the new CFC 804C with the "last day of coverage" date, DCF will update the long panel with the new end date provided by the nursing facility, not to exceed a total of 100 days from admission.
8. **Long Panel Medicaid Only Stays**: DCF verifies VT Medicaid coverage based on the notification from the nursing facility. DCF enters a long panel in the ACCESS system with both a start and end date using the Highest Need category. The start date is the admission

date. The end date is the discharge date reported by the nursing facility up to 30 days total (60 days per calendar year). If the nursing facility does not report the end date on the admission notification, DCF enters 30 days total.

9. **Dual Medicare/Medicaid Claims**: The nursing facility bills Medicare following Medicare rules. After the Medicare claim is paid, VT Medicaid automatically pays the co-insurance "crossover claim" following the Medicare period of coverage.
10. **Medicaid Only Claims**: The nursing facility bills VT Medicaid using revenue code 128 up to 30 days (60 days per calendar year).
11. **Discharge Planning**: The nursing facility must assist the individual with discharge planning prior to the end of the rehab stay.
12. **DCF Notice of Discharge**: The nursing facility must notify DCF of the actual discharge date using the CFC804C.
13. **Changes in payer source for rehab stay**: The nursing facility must notify DCF and DVHA using the CFC 804B if there is a change in payer source during a stay.
14. **Continued Choices for Care Eligibility**: If at any time during a short-term covered stay, the nursing facility believes the individual continues to need nursing home level of care, the nursing facility must discuss options with the individual and assist the individual in submitting an application for Choices for Care if desired by the individual or their legal representative.
15. **Active Choices for Care participants**: Active Choices for Care (CFC) participants continue to have a choice of setting and may transition to an approved VT Medicaid nursing facility following existing CFC program standards.
16. **Specialized Out-of-State Rehab:** A person seeking "specialized rehab" at an out-of-state facility considered a "specialized rehabilitation" facility must receive prior-authorized by DAIL for each admission. This includes a clinical review of need, verification that the need cannot be met in any standard Vermont nursing facility or other CFC covered service, approval of the plan of care and a rate-setting review.

SECTION V.2. Waiting List Procedures

Active Choices for Care (CFC) participants who meet the "High Needs" clinical criteria at reassessment will not be terminated from services as long as they continue to meet all other CFC eligibility criteria. *(See Section II. Eligibility)*

New Long-Term Care Medicaid (CFC) applicants who meet the "High Needs" clinical criteria may be placed on a waiting list if State funds are not available at the time of referral, using the following procedures:

1. If funds are not available at time of application, **Department of Disabilities, Aging and Independent Living (DAIL) staff** will complete a High Needs Wait List Score Sheet.

2. A score will be generated based on the individuals Activities of Daily Living (ADL), Cognition, Behavior, Medical Conditions/Treatments and Risk Factors.

3. DAIL staff will then place the individual on a waiting list in order of score.

4. DAIL staff will notify the individual in writing that they have been found clinically eligible for the High Needs Group and have been placed on a wait list. The case management agency that the applicant chose on the application will be in contact with them. Appeal rights will also be included in the notice.

5. DAIL staff will forward a copy of the CFC program application and Wait List Score Sheet to the Case Management (CM) agency indicated on the application. The application will not be sent if the CM agency assisted in completing the application.

6. The case manager/agency will make contact individuals on the "High Needs" wait list on a monthly basis to monitor if they have had a change in their health or functional needs and complete the High Needs Waiting List Monthly Follow-Up Sheet. The initial contact will occur no later than 14 days after receiving the referral.

7. If the individual has had a significant health or functional status change the case manager will contact DAIL staff. DAIL staff shall reassess for clinical eligibility determination and/or rescore for wait list. Agencies are encouraged to use the Triggers for High Needs Wait List Referral for Clinical Review as a guide to determine if another clinical assessment is warranted.

8. DAIL staff & providers will review the wait list with the CFC waiver team at monthly meetings.

9. Each case management agency designee (determined by the CM agency) will ensure that a copy of the follow-up sheet for all applicants on the High Needs wait list monitored by their agency and send to DAIL Waterbury by the 5th of each month.

10. DAIL staff in Waterbury will follow up with the CM agency if any High Needs Waiting List Monthly Follow-up Sheets are missing.

11. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:

    a. Unmet needs for ADL assistance;
    b. Unmet needs for IADL assistance;
    c. Behavioral symptoms;
    d. Cognitive functioning;
    e. Formal support services;
    f. Informal supports;
    g. Date of application;
    h. Need for admission to or continued stay in a nursing facility;
    i. Other risk factors, including evidence of emergency need; and
    j. Priority score.

12. When funding is allocated to an individual, DAIL staff will notify the individual and continue the CFC application process.

SECTION V.3. Initial Assessment & Reassessment Procedures

I. Initial Assessment Procedures

After the Department of Disabilities, Aging and Independent Living (DAIL) staff determines clinical eligibility and sends Clinical Authorization to DCF and the chosen case management agency, a comprehensive assessment must be completed in order to develop a Service Plan for Choices for Care (CFC) services. The assessment procedure is determined by the following CFC settings:

A. Home-Based Initial Assessment (Fee for Service)

1. Case manager, together with the individual, shall complete a full assessment (ILA) within 14 calendar days of receipt of the Clinical Certification.

2. The **case manager may use the information from the DAIL LTCCC assessment for the initial assessment health information or have** a registered nurse completes the Health Assessment portion of the ILA.

3. The case manager, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

4. The case manager, together with the individual, shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

5. The case manager, together with the individual, shall identify, if any, the informal/family supports that will continue.

6. The case manager, together with the individual, shall review the service options and service limitations with the individual, surrogate, and/or guardian.

7. The case manager, together with the individual shall select services and develop a comprehensive Service Plan with the individual that is appropriate to the identified needs, and in compliance with existing CFC service definitions, standards, procedures, and limitations.

8. The case manager shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The case manager shall sign the Service Plan.

10. The case manager shall review and complete an "In-Home Back-up Care & Emergency Plan" form with the individual. The plan shall be posted in an obvious location within the individual's home.

11. The case manager shall compile and submit a complete assessment package to DAIL.

12. The case manager shall ensure that the package is complete, containing the following

documents:

a. Proposed Service Plan
b. Personal Care Worksheet
c. Independent Living Assessment (ILA)
d. Assistive Devices and Modifications Addendum (if applicable)
e. Employer Certification Form (if applicable for Participant/surrogate-directed only)
f. Variance request(s) (if applicable)
g. Live-In Agreement (if applicable)

13. DAIL staff shall return incomplete initial assessment packets to the case manager.

14. The case manager shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or Participant).

15. The case manager and providers shall follow procedures for "Initiating Services".

16. DAIL staff shall complete Utilization Review (UR).

17. DCF staff shall complete CFC financial eligibility and send notice to individual, provider and DAIL.

18. DAIL staff shall verify CFC financial eligibility.

19. If the individual meets the financial eligibility criteria, DAIL staff shall authorize the initial Service Plan, including any adjustments as determined in the UR process.

20. DAIL staff shall mail approved Service Plan to the individual, case manager and providers.

21. DCF staff shall mail a denial letter with appeal rights, to individuals do not meet the CFC financial eligibility criteria. A copy of the denial notice will be send to DAIL staff.

B. Home Based Adult Family Care (AFC)

1. The Case Manager shall follow the same process as in A. Home-Based Initial Assessment steps 1-7. If the participant chooses Adult Family Care as their home-based option, the case manager provides the participant with a choice of Authorized Agencies (AA) and assists the participant with a referral to the AA.

2. After completing the ILA within 14 working days of receipt of the Clinical Certification, the Case Manager shall provide a copy of the AFC ILA assessment (including the Tier Worksheet) to the Authorized Agency (AA), if identified, and to DAIL staff.

3. DAIL staff will complete the utilization review of the AFC ILA assessment and Tier.

4. DAIL staff will report the confirmed Tier to the Case Manager. The Case Manager will report the Tier to the AA, if identified.

5. If the AA is unknown during steps 1-4, when the AA is identified the Case Manager will

send a copy of the AFC ILA and the Tier to the AA the participant has chosen.

6. If the AA is not able to serve the participant, the Case Manager will review the AA options and have the participant choose a new AA .

7. If the AA agrees to serve the participant, the Case Manager will work with the participant and AFC Coordinator to assist with the home provider matching process.

8. When a home provider match is made, the AFC Coordinator, together with the Case manager and the participant, will create a move-in plan.

9. When the participant move-in date is set, the Case Manager shall obtain the signature of the participant or legal representative, the Authorized Agency, the home provider and the case manager on the Service Plan.

10. The Case Manager shall submit the AFC service plan to DAIL.

11. The Case Manager shall ensure that DAIL has received the following documents:
    a. AFC ILA, including the tier worksheet
    b. AFC service plan
    c. Written Justification for Dual Participation in Hospice (if applicable)

12. DAIL shall return incomplete documents to the Case Manager.

13. The Department for Children and Families (DCF) Economic Services Division (ESD) shall complete LTC Medicaid financial eligibility and send notice to the individual, DAIL, and the individuals' alternate reporters.

14. DAIL shall verify CFC financial eligibility and authorize the initial AFC Service Plan, including any adjustments to the tier as determined in UR process.

15. DAIL shall mail approved AFC Service Plan to the individual and Case Manager.

16. The Case Manager will provide a copy of the approved and authorized service plan to the Authorized Agency.

17. DCF staff shall mail a denial letter with appeal rights to individuals who do not meet the CFC financial eligibility criteria. A copy of the denial notice will be sent to the individual and DAIL staff.

18. The AA shall follow procedures for "Initiating Services".

C. Enhanced Residential Care (ERC) Initial Assessment

1. The ERC provider, together with the individual, must complete a full resident assessment within 14 calendar days of receipt of the Clinical Certification, or admission (whichever comes first) together with the case manager whenever possible.

2. The ERC provider shall ensure that a registered nurse completes or signs-off on the assessment.

3. The Licensed Level III Residential Care Home that is an ERC provider must submit a variance request to the Division of Licensing and Protection (DLP) for permission to serve or retain the individual if they have reached their pre-approved variance amount.

4. The ERC provider shall provide a copy of the resident assessment to the case manager.

5. The case manager shall complete an ERC Tier worksheet and ERC Service Plan.

6. The case manager shall obtain the signature of the applicant or legal representative on the Service Plan.

7. The case manager and the ERC provider shall sign the Service Plan.

8. The case manager shall compile and submit a complete assessment package to DAIL.

9. The case manager shall ensure that the package is complete and contains the following documents:
   a. Proposed Service Plan
   b. Tier Worksheet
   c. Comprehensive Resident Assessment (CRA)
   d. Written Justification for Dual Participation in Hospice (if applicable)
   e. Variance Request Form (when applicable)

10. DAIL shall return incomplete initial assessment packets to the case manager.

11. DAIL shall complete Utilization Review (UR).

12. The Department for Children and Families (DCF) shall complete LTC Medicaid financial eligibility and send notice to individual, provider and DAIL.

13. DAIL shall verify CFC financial eligibility.

14. DAIL shall verify the Level of Care Variance issued by Department of Licensing and Protection (DLP).

15. DAIL shall authorize the initial Service Plan, including any adjustments as determined in UR process.

16. DAIL shall mail approved Service Plan to the individual, case manager and providers.

17. DCF staff shall mail a denial letter with appeal rights to individuals who do not meet the CFC financial eligibility criteria. A copy of the denial notice will be send to DAIL staff.

18. DAIL shall send a denial letter with appeal rights to individuals who are denied a variance by DLP.

19. The ERC provider shall follow procedures for "Initiating Services".

D. Nursing Facility (NF) Initial Assessment

1. The NF provider shall assist the applicant with the ESD/DAIL 202 LTC application when necessary.

2. The NF provider, together with the individual, shall complete the Minimum Data Set (MDS) according to existing State and Federal nursing facility regulation.

3. DCF staff shall complete CFC financial eligibility and send notice to individual, NF provider and DAIL.

4. The NF provider shall follow procedures for "Initiating Services" and shall develop individual service plans for all residents, in compliance with prevailing conditions of participation and licensing regulations.

5. DCF staff shall mail a denial letter with appeal rights to individuals do not meet the LTC Medicaid financial eligibility criteria. A copy of the denial notice will be send to DAIL staff and NF provider.

II. Reassessment Procedures

Individuals participating in CFC services must have a comprehensive reassessment completed on a regular basis. The reassessment procedure is determined by the following CFC settings:

A. Home-Based Reassessment

1. The case manager, together with the individual, shall complete a full reassessment (ILA) at least once every 365 days. The reassessment must be completed, submitted and received at DAIL at least one month prior to the previous plan of care end date.

2. The case manager, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

3. The case manager, together with the individual, shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

4. The case manager shall identify, if any, the informal/family supports that will continue.

5. The case manager shall review the service options and service limitations with the individual, surrogate, and/or guardian.

6. The case manager, together with the individual, shall select services and develop a comprehensive Service Plan with the individual that is appropriate to the identified needs, and in compliance with existing CFC service definitions, standards, procedures, and

limitations.

7. The case manager shall ensure that a registered nurse completes the Health Assessment portion of the ILA.

8. The case manager shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The case manager shall sign the Service Plan.

10. The case manager shall compile and submit a complete reassessment package to DAIL.

11. The case manager shall ensure that the package is complete, containing the following documents:
    a. Proposed Service Plan
    b. Personal Care Worksheet
    c. Independent Living Assessment (ILA)
    d. Assistive Devices and Modifications Addendum (if applicable)
    e. Employer Certification Form (if applicable for Participant/surrogate-directed only)
    f. Variance request(s) (when applicable)
    g. Live-In Agreement (if new or different)

12. DAIL staff shall return incomplete reassessment packets to the case manager

13. The case manager shall assist the applicant with the Long-Term Care Medicaid financial eligibility reviews when necessary.

14. The case manager shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or Participant).

15. DAIL staff shall complete Utilization Review (UR).

16. DAIL staff shall authorize the Service Plan, including any adjustments as determined in UR process.

17. DAIL staff shall mail approved Service Plan to the individual, case manager and providers.

B. Adult Family Care

1. The Case Manager, together with the participant and AA Coordinator, shall follow the same steps as outlined above in A. Home-Based Reassessments, steps 1-10. The reassessment must be completed, submitted and received at DAIL at least one month prior to the previous plan of care end date.

2. The Case Manager shall ensure that DAIL has received the following documents:
    a. AFC ILA, including the tier worksheet
    b. AFC service plan
    c. Written Justification for Dual Participation in Hospice (if applicable)

3. DAIL staff shall return incomplete reassessment packets to the case manager.

4. The AFC Coordinator shall assist the applicant with the Long-Term Care Medicaid financial eligibility reviews when necessary.

5. DAIL staff shall complete Utilization Review (UR).

6. DAIL staff shall authorize the Service Plan, including any adjustments as determined in UR process.

7. DAIL staff shall mail approved Service Plan to the individual, case manager and providers.

C. Enhanced Residential Care (ERC) Reassessment

1. The ERC provider, together with the individual, must complete a resident reassessment (RA) at least once every 365 days, together with the case manager whenever possible. The reassessment must be completed, submitted and received at DAIL prior to the previous plan of care end date.

2. The ERC provider, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

3. The ERC provider shall ensure that a registered nurse completes or signs-off on the reassessment.

4. The ERC provider shall provide a copy of the RA to the case manager.

5. The case manager shall complete an ERC Tier worksheet and ERC Service Plan.

6. The case manager shall obtain the signature of the applicant or legal representative on the Service Plan.

7. The case manager shall sign the Service Plan.

8. The case manager shall compile and submit a complete reassessment package to DAIL.

9. The case manager shall ensure that the package is complete, containing the following documents:
    a. Proposed Service Plan
    b. Tier Worksheet
    c. Resident Assessment

10. DAIL staff shall return incomplete reassessment packets to the case manager.

11. The case manager shall assist the applicant with the Long-Term Care Medicaid financial eligibility reviews when necessary.

12. DAIL staff shall complete Utilization Review (UR).

13. DAIL staff shall authorize the Service Plan, including any adjustments as determined in UR process.

14. DAIL staff shall mail approved Service Plan to the individual, case manager and providers.

D. Nursing Facility (NF) Reassessment

1. The NF provider, together with the individual, shall complete the Minimum Data Set (MDS) and individual service plan in compliance with prevailing conditions of participation and licensing regulations.

2. The NF provider shall assess the individual's circumstances, resources, strengths and needs.

3. The NF provider shall assist the applicant with the Long-Term Care Medicaid financial eligibility review when necessary.

E. Hospice Program

Individuals participating in the Choices for Care program who become eligible for, and in need of Home Health Hospice services may do so without prior authorization from DAIL. It is the understanding of both DAIL and the Home Health hospice providers that dual participation will occur under the following conditions:

1. Hospice staff will inform the CFC case manager immediately when a CFC participant is admitted to hospice.

2. Individuals must continue to meet the criteria for both CFC and hospice services.

3. When ever possible, hospice funded services must be maximized and utilized prior to waiver services (e.g. LNA, Homemaker).

4. When appropriate, the CFC case manager will submit a plan of care change to reflect any reduction in waiver time for activities that are being provided by hospice (e.g. bathing, grooming).

5. It is the responsibility of the local home health agency to contact DAIL no later than one week after the individual is admitted to hospice services. DAIL will track the following information:
    - Participant name,
    - Agency name,
    - Hospice diagnosis,
    - Anticipated length of hospice service,
    - Hospice admission date,
    - Payment source,
    - Hospice contact,

- Copy of Hospice plan.

This information may be mailed, faxed or emailed to DAIL.

SECTION V.4. Monitoring Procedures

All Choices for Care (CFC) services must be monitored on a regular basis to ensure that the participants' needs, and person-centered goals are identified, and the desired outcomes of individuals are being met. The monitoring procedures are determined by the following CFC settings:

A. Home-Based Monitoring

1. The case manager shall have monthly contact with the individual. Face-to-face visits must occur not less than once every 60 days. At a minimum, an annual face to face visit must be in the home of the individual.

2. The case manager shall monitor all needs of the individual including, but not limited to:
   a. Health and functional status
   b. Environmental needs
   c. Health and welfare issues
   d. Abuse, neglect and exploitation issues
   e. Social and recreational needs
   f. Public benefits including CFC financial eligibility
   g. Participant and surrogate employer certification status
   h. Family issues
   i. Coordination with CFC providers
   j. Needs related to other services outside of CFC

3. The case manager shall document the monitoring visits and other case management activities. Documentation shall be maintained in the individual's case management case file.

4. The case manager shall track the amount of time spent each month on approved case management activities.

5. If there is a significant change in the individual's condition or circumstances, the case manager shall communicate with the appropriate provider(s) and initiate a Service Plan change or full reassessment if necessary.

6. If at any time, information suggests that the individual may no longer meet CFC clinical eligibility criteria, the case manager shall communicate with the individual, legal representative and provider(s) and arrange a health and function assessment to be reviewed by DAIL.

7. If information suggests the individual no longer meets the financial eligibility criteria for CFC services, the case manager shall communicate with the individual, legal representative, provider(s) and the Department of Vermont Health Access (DVHA).

8. The case manager shall assist the individual, as necessary, with any Long-Term Care Medicaid financial review forms as required by DVHA.

9. The case manager shall monitor the need for services outside of CFC and coordinate referrals as needed.

10. The case manager shall monitor the ongoing ability of participant and surrogate employers to follow "Employer Responsibilities". If at any time the participant or surrogate employer demonstrates an inability to perform employer activities, the case manager will complete a new "Employer Certification".

11. Home Health Agency providers shall complete an in-home visit for individuals they provide services to, at least once every 60 days to monitor employee(s) activities, assuring the following:
    a. Services are being provided according to the personal care worksheet and approved Service Plan.
    b. Volume of services being provided is sufficient to meet the individual's needs.
    a. The schedule of services is sufficient to meet the individual's needs as identified in the assessment.
    b. Personal care activities are being performed safely and successfully.
    c. The individual is satisfied with his or her personal care attendant.
    d. Services provided to the individual are accurately documented by staff on applicable tracking forms and timesheets.

12. Participant directed employers shall monitor employee(s) activities on an ongoing basis to assure the following:
    a. Services are being provided according to the personal care worksheet and approved Service Plan.
    b. Volume of services being provided is sufficient to meet the individual's needs.
    c. The schedule of services is sufficient to meet the individual's needs as identified in the assessment.
    d. Personal care activities are being performed safely and successfully.
    e. The individual is satisfied with his or her employee(s).
    f. Services provided to the individual are accurately documented by staff on applicable tracking forms and timesheets.

13. Surrogate directed employers shall complete an in-home visit at least once every 30 days to monitor employee(s) activities, assuring the following:
    a. Services are being provided according to the personal care worksheet and approved Service Plan.
    b. Volume of services being provided is sufficient to meet the individual's needs.
    c. The schedule of services is sufficient to meet the individual's needs as identified in the assessment.
    d. Personal care activities are being performed safely and successfully.
    e. The individual is satisfied with his or her employee(s).
    f. Services provided to the individual are accurately documented by staff on applicable tracking forms and timesheets.

14. The Division of Licensing and Protection (DLP) will regularly monitor Home Health providers for compliance with applicable State and Federal regulations.

15. The Department of Disabilities, Aging and Independent Living (DAIL) will monitor the provision of Case Management Services on a regular basis to ensure compliance with standards and procedures.

B. Flexible Choices Monitoring

1. Monitoring and Troubleshooting:
   a. During the budgeting process, the consultant and the participant establish a monitoring process which lays out the schedule by which the consultant will contact the participant to see how the plan is functioning and how well the participant is doing.
   b. The consultant also reviews the bi-weekly financial statement to assure that the participant's plan is being properly implemented.
   c. Consultants must contact participants weekly for the first month and monthly thereafter. That monthly contact will include: check wording on previous version.
      i. Review and update, if appropriate, of the participant's goals
      ii. Review of the budget including budget expenditures
      iii. Ascertaining the participant's perception of their wellbeing
      iv. Discussion of any problems or concerns perceived by the consultant
   d. Consultants will perform a home visit whenever the participant requests it. Consultants may initiate a home visit if they consider it called for. Home visits will occur at least annually to complete the annual reassessment by the RN
   e. Participants are expected, however, to implement their emergency back-up plans should they need immediate assistance
   f. When participants need support with their Flexible Choices budget or allowance, they may contact the consultant.

C. Adult Family Care

1. The AFC coordinator shall have contact with the participant no less than once every 30 days and a face-to-face no less than once every 60 days.

2. The monitoring shall include, but is not limited to the following needs of the participant:
   a. Health and functional status
   b. Environmental needs
   c. Health and welfare issues
   d. Abuse, neglect and exploitation issues
   e. Social and recreational needs
   f. Public benefits including CFC financial eligibility
   g. AFC Home Provider issues
   h. Coordination with providers
   i. Needs related to other services outside of CFC

3. The AFC coordinator shall communicate with the AFC Home no less than once every 60 days.

4. The AFC coordinator shall document the monitoring visits and other activities. Documentation shall be maintained in the participant's file.

5. If there is a significant change in the individual's condition or circumstances, the AFC coordinator shall communicate with the Home Provider and legal representative and initiate a Service Plan change or full reassessment if necessary.

6. If at any time, information suggests that the participant may no longer meet CFC clinical eligibility criteria, the AFC coordinator shall communicate with the individual, legal representative and AFC Home Provider and will arrange a health and functional assessment to be completed and reviewed by DAIL.

7. If information suggests the individual no longer meets the financial eligibility criteria for CFC services, the AFC coordinator communicate with the individual, legal representative the AFC Home and Department of Vermont Health Access (DVHA).

D. Enhanced Residential Care (ERC) Monitoring

1. The provider shall monitor needs of the individual including, but not limited to:
    a. Health and functional status
    b. Environmental needs
    c. Health and welfare issues
    d. Abuse, neglect and exploitation issues
    e. Social and recreational needs
    f. Public benefits including CFC financial eligibility
    g. Family issues
    h. Coordination with ERC providers
    i. Needs related to other services outside of CFC

2. The provider shall document monitoring activities in the individual's file.

3. If there is a significant change in the individual's condition or circumstances, the provider shall communicate with the individual and legal representative and initiate a Service Plan change or full reassessment if necessary.

4. If at any time, information suggests that the individual may no longer meet CFC clinical eligibility criteria, the provider shall arrange a health and function assessment to be reviewed by DAIL.

5. If information suggests the individual no longer meets the financial eligibility criteria for CFC services, the provider shall communicate with the legal representative, DAIL and the Department of Vermont Health Access (DVHA).

6. The provider shall assist the individual and legal representative, as necessary, with any Long-Term Care Medicaid financial review forms as required by DVHA.

7. The provider shall monitor the need for services outside of CFC and coordinate referrals as needed.

8. Providers shall monitor the needs of the individual according to existing regulations.

9. The Division of Licensing and Protection (DLP) will regularly monitor ERC providers for compliance with applicable State and Federal regulations.

10. The Department of Disabilities, Aging and Independent Living (DAIL) will monitor the provision of ERC services as needed to ensure compliance with standards and procedures.

E. Nursing Facility (NF) Monitoring

1. The NF provider shall complete the Minimum Data Set (MDS) according to existing NF regulations.

2. The NF provider shall monitor the individual's needs according to State and Federal regulation.

3. If at any time, information suggests that the individual may no longer meet CFC clinical eligibility criteria, the NF provider shall communicate with the DAIL staff and arrange a health and function assessment to be reviewed by DAIL.

4. The DLP will regularly monitor NF for compliance with State and Federal regulations.

SECTION V.5. Changes & Start Date Procedures

I. Change in Services Procedures

The procedure for reporting changes is determined by the following Choices for Care (CFC) settings:

A. Home-Based (fee for service) Service Changes

1. The case manager shall complete a Service Plan change when the individual has a significant change in physical or cognitive function that may increase or decrease the need for CFC services prior to the annual reassessment.

2. The case manager shall ensure that an RN has completed and signed the ILA health assessment if applicable.

3. The case manager shall assess the individual's circumstances, resources, strengths and needs.

4. The case manager shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

5. The case manager shall identify, if any, the informal/family supports that will continue.

6. The case manager shall review the service options and service limitations with the individual, surrogate, and/or guardian.

7. The case manager shall select services and develop a comprehensive Service Plan appropriate to the identified needs, and in compliance with existing CFC service definitions, standards, procedures, and limitations.

8. The case manager shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The case manager shall sign the Service Plan.

10. The case manager shall compile and submit the complete Service Plan change package to the Department of Disabilities, Aging and Independent Living (DAIL) regional office. The case manager shall ensure that the package is complete, containing the following documents:
    a. Proposed Service Plan
    b. Personal Care Worksheet (for changes in personal care and adult day)
    c. Justification for change (e.g. ILA health, or functional assessment, etc.)
    d. Assistive Device/Home Modifications addendum (if applicable)
    e. Employer Certification Form (if changing to Participant/surrogate-directed only)
    f. Variance request (if personal care time exceeds worksheet maximums)
    g. A copy of the hospice plan for Dual Participation in Hospice & CFC (if applicable)

11. DAIL shall return incomplete change packets to case manager.

12. The case manager shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or Participant) when applicable.

13. DAIL shall complete Utilization Review (UR).

14. DAIL shall authorize the Service Plan, including any adjustments as determined in UR process.

15. DAIL shall mail approved Service Plan to the individual and providers and FAX to payroll agent when applicable.

B. Flexible Choices Allowance & Budget Changes

Allowance:

1. The consultant shall complete an allowance change when the individual has a significant change in physical or cognitive function that may increase or decreased need for CFC services prior to the annual reassessment.

2. The consultant shall ensure that an updated ILA and allowance is completed and sent to the local DAIL LTCCC for review.

3. DAIL shall complete Utilization Review (UR).

4. DAIL shall authorize the allowance, including any adjustments as determined in UR process.

5. DAIL shall send the approved allowance to the individual and consultant agency.

Budget:

The consultant will forward all budget and allowance allocation changes to the Fiscal ISO and the participant. Budget changes occur in two forms:

1. Budget changes that come about because the participant's needs have changed. This requires a new needs assessment to determine a new allowance amount and that process is detailed in "Determining the Allowance." A new budget would then be developed as laid out in the section "Budget Development."

2. Budget changes that come about not because of a change in participant needs. These changes reflect a change in participant priorities, or a new approach to meet existing goals. They do not require a new needs assessment but require a modification of all relevant sections of the Budget Form, including goals. These require only steps 8 – 11 listed in the "Initiation of Services" section.

C. Adult Family Care Home Service Changes

1. The Home Provider or AFC coordinator will contact the case manager to do a reassessment when the participant has a significant change in physical or cognitive function.

2. The case manager shall complete an ILA when the individual has a significant change that may increase or decrease the need for CFC services prior to the annual reassessment.

3. The case manager shall ensure that an RN has completed and signed the ILA health section if applicable.

4. The case manager with the participant (and care team when possible) shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

5. The case manager shall identify, if any, the informal/family supports that will meet the unmet needs.

6. When the change in needs affects the AFC Tier the case manager will complete the AFC tier score sheet and if there is a change complete an AFC Service Plan.

7. The case manager will obtain the necessary signatures on the AFC Service Plan.

8. The case manager will submit all required documents (ILA, AFC Tier Score sheet & AFC Service Plan) to the DAIL regional office (LTCCC).

9. If the change includes the enrollment into Hospice the case manager will obtain a copy of the Hospice plan and submit it with the CFC documentation.

10. DAIL shall complete Utilization Review (UR).

11. DAIL shall authorize the Service Plan, including any adjustments as determined in UR process.

12. DAIL shall mail or fax or email the approved Service Plan to the individual and providers.

D. Enhanced Residential Care (ERC) Service Changes

1. If the individual has had a significant change in physical or cognitive function, the ERC provider must complete a new assessment (RA), together with the case manager whenever possible.

2. The ERC provider shall assess the individual's circumstances, resources, strengths and needs.

3. The ERC provider shall ensure that a registered nurse completes or signs-off on the reassessment.

4. If the ERC provider believes the new assessment will result in a ERC Tier change, the ERC

provider shall provide a copy of the RA to the case manager.

5. The case manager shall complete an ERC Tier worksheet.

6. If the ERC Tier has changed, the case manager shall complete a CFC ERC Service Plan.

7. The case manager shall obtain the signature of the applicant or legal representative and ERC Provider on the Service Plan.

8. The case manager shall sign the Service Plan.

9. The case manager shall compile and submit a complete change package to DAIL regional office (LTCCC). The case manager shall ensure that the package is complete, containing the following documents:
    a. ERC Service Plan
    b. ERC Tier Worksheet
    c. Resident Assessment (RA)
    d. Permission for Release of Information (if applicable)
    e. Hospice Plan for Dual Participation in Hospice (if applicable)

10. DAIL shall return incomplete packets to the case manager.

11. DAIL shall complete Utilization Review (UR).

12. DAIL shall authorize the Service Plan, including any adjustments as determined in UR process.

13. DAIL shall mail approved Service Plan to the individual, case manager and ERC provider.

E. Nursing Facility (NF) Service Changes

1. The NF provider shall complete the Minimum Data Set (MDS) according to existing NF regulation.

2. The NF provider shall assess the individual's circumstances, resources, strengths and needs.

3. The NF provider shall complete a "Change Report Form" for active Choices for Care participants when:
    a. The individual is requesting a change of setting (to home-based or ERC) within Choices for Care,
    b. The individual has been admitted to the hospital,
    c. The individual been readmitted to the NF after a hospital stay,
    d. The individual has had a change in payor source, or
    e. The individual terminates from Choices for Care. (*See Denials and Terminations*)

II. Transfer of Setting Procedures

Individuals may transfer between CFC settings at any time using the following procedures.

A. Home-Based or Enhanced Residential Care (ERC)➔ Nursing Facility (NF)

1. The **individual, family and/or case manager or consultant** must ensure that a NF is available and willing to accept the individual as a resident.

2. The **individual and/or family** must complete all applicable NF admission forms with help from the case manager and nursing home provider when necessary.

3. **Case manager or consultant** shall complete a "Change Report" form (CFC 804) and send to DAIL, DCF and the NF provider.

4. The **NF provider** shall complete an MDS according to existing regulations.

5. **DCF** shall recalculate the patient share and send notice to the individual, DAIL, and NF provider.

B. Home-Based➔ ERC

1. The **individual, family and/or case manager** must ensure that an ERC provider is available and willing to accept the individual as a resident.

2. The **individual and/or family** must complete all applicable ERC admission forms with help from the case manager and ERC provider when necessary.

3. **Case manager** and **ERC provider** shall follow the Initial Assessment Procedures for ERC setting.

C. Flexible Choices➔ any other CFC option

1. For Home-based and ERC transitions, the **participant** shall choose a case management agency (HHA or AAA).

2. The **consultant** shall complete a "Change Report" form (CFC 804) and send to DAIL, DCF, the case management agency and applicable CFC provider.

3. The **case manager** will complete a new assessment if needed. The amount of services the participant receives in the new option will be determined by their assessed need at the time of the transfer from Flexible Choices.

4. The **consultant** shall work with the participant and the receiving option to assure a smooth transition to the new option.

5. Whenever possible, the **participant or surrogate** employer shall give their employees reasonable notice that their services will no longer be required.

D. ERC ➔ Home-Based

1. The **individual, family and/or case manager** must ensure that a home is available in the community for the individual to reside.

2. **Case manager** shall follow the Initial Assessment Procedures for Home-Based setting.

E. Nursing Facility (NF) ➔ Home-Based or ERC

1. The NF **provider** shall ask the participant which choices for care setting option they would like to pursue.

2. The NF provider will offer the participant the case management choices.

3. The NF will make a referral to the participant's chosen case management agency.

4. The NF will complete a "Change Report" form and send to DAIL and DCF.

5. **If DAIL staff** receive a 804a from a NF for a transfer to another setting from a NF prior to receiving a HB or ERC Service Plan and ILA they will make a referral to case management agency indicated on the form.

6. **Case manager** shall follow the Initial Assessment Procedures for Home-Based setting or ERC setting.

7. For Home-Based the **case manager** must complete the ILA within 14 calendar days of completion of receipt of the referral.

8. For ERC the **ERC provider** follow the level of care variance procedure and complete the RA within 14 calendar days of admission.

III. Other Changes

A. Financial Changes: The **individual or legal representative** is responsible for reporting all changes in the income or resources to the local Department for Children and Families according to their policies.

B. Address Changes: A "Change Report" form must be completed any time an individual has a change in address. For the home-based ERC setting, the **case manager** completes the form. For NF setting, the **NF provider** completes the form. The form must be sent to DAIL and DCF.

C. Legal Representative Change: A "Change Report" form must be completed any time an individual has a change in legal representative. For the home-based ERC setting, the **case manager** completes the form. For NF setting, the **NF provider** completes the form. The form must be sent to DAIL and DCF.

D. Hospital Admissions: **NF providers** must complete a "Change Report" CFC 804B form when an individual is admitted to a hospital and plans on returning to the nursing facility. The Change Report form must be mailed to DCF, and DVHA.

E. Terminations: A "Change Report" form must be completed when individuals terminate from "Choices for Care". For the home-based ERC setting, the **case manager** completes the CFC 804 Change form. For NF setting, the **NF provider** completes the CFC 804A Discharge form. The form must be sent to DAIL and DCF. Terminations include:

- Death
- Permanent move out of state
- Temporary stay our of state exceeding 30 continuous days
- The individual no longer requires Choices for Care services (condition has improved or other services meeting their needs)

For more information, refer to manual Section V.7. Denials and Terminations.

F. Readmission from Hospital: **NF providers** must complete a "Change Report" CFC 804B form when an individual is readmitted to the NF from a hospital stay. The Change Report form must be mailed to DCF, and DVHA.

IV. Effective Start Dates

A. Initial Service Authorization

The effective start date that the Department of Disabilities, Aging and Independent Living (DAIL) will use when authorizing services will be the latest of the following:

1. Date of Application date, or

2. Date off of wait list (if applicable), or

3. Date of Long-Term Care Medicaid eligibility (per the Department for Children and Families notice), or

4. Home-Based (fee for service and flexible choices options): Date Assessment/Service Plan completed if completed more than 14 days after receipt of the Clinical Certification.

5. ERC: Date Level of Care Variance issued by Department of Licensing and Protection for Residential Care Home

6. NF: Date of admission

7. AFC: Date moved into AFC Home

B. Annual Service Plan (Reassessment)

The effective start date that DAIL will use when authorizing Home-Based and ERC Service Plans upon reassessment will be the day after the previous Service Plan expired.

C. Service Plan Changes

The effective start date for all Home-Based and ERC service changes (except Participant or surrogate directed services), will be no earlier than the date the Service Plan is received at the DAIL regional office.

The effective start date for Participant or surrogate-directed service changes (Home-Based Fee for Service and Flexible Choices) will be no earlier than the start of the next payroll period after the Service Plan is received at the DAIL regional office.

D. Retroactive Change Requests

1. Retroactive requests for an increase in Home-Based or ERC services will be considered for approval only under certain circumstances when a precipitating event necessitates an immediate increase of services exceeding the currently approved volume of services.

2. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility (NF) placement. For example: The home-based primary caregiver is hospitalized or the individual has a medical event that requires immediate increase in services.

3. Retroactive Service Plan changes will not be approved to cover administrative errors or non-emergent requests for increases.

4. All requests for retroactive coverage must accompany a Service Plan change, a written request for a specific start date and a description of the precipitating event.

SECTION V.6. Initiating Services Procedures

A. Home-Based Setting

1. The case manager shall arrange and coordinate the initiation of services.

2. If the case manager and provider(s) believe that the applicant meets Choices for Care (CFC), Long-Term Care Medicaid financial eligibility criteria, services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) "Clinical Certification" is made, with a mutual agreement between the provider and the individual or legal representative concerning payment for services rendered prior to final Department for Children and Families (DCF) financial eligibility approval.

3. Individuals shall be informed by the case manager that, by starting services in advance of final CFC financial eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible for CFC services.

4. In the event that there is a question regarding the individual's potential CFC financial eligibility, the provider may delay the initiation of CFC services until the DCF has determined CFC financial eligibility and DAIL has authorized the Service Plan.

5. The provider shall not bill the State for CFC services provided until DCF has approved financial eligibility and DAIL has authorized the CFC Service Plan.

6. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the provider may bill the individual for services provided, as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

B. ERC Setting

1. The case manager shall arrange and coordinate the initiation of services.

2. If the case manager and provider(s) believe that the applicant meets Choices for Care (CFC), Long-Term Care Medicaid financial eligibility criteria, and the Residential Care Home has been issued a Level of Care Variance by the Department of Licensing and Protection (DLP), services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) "Clinical Certification" is made, with a mutual agreement between the provider and the individual or legal representative concerning payment for services rendered prior to final Department for Children and Families (DCF) financial eligibility approval.

3. Individuals shall be informed by the case manager that, by starting services in advance of final CFC financial eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible

for CFC services.

4. In the event that there is a question regarding the individual's potential CFC financial eligibility, the provider may delay the initiation of CFC services until the DCF has determined CFC financial eligibility and DAIL has authorized the Service Plan.

5. The provider shall not bill the State for CFC services provided until DCF has approved financial eligibility and DAIL has authorized the CFC Service Plan.

6. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the provider may bill the individual for services provided, as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

C. Flexible Choices (FC)

1. Initiation of Services for new CFC applicants:

   a. Clinical eligibility is determined by regional LTCCC
   b. Referral is made to the Consultant Agency by the LTCCC sending a copy of the clinical certification form (CFC 803).
   c. The consultant will send out a copy of the Welcome Letter, Self-Screening Form, Welcome to Flexible Choices booklet, Flexible Choices brochure, Rewarding Work brochure, Referral form (if not sent already).
   d. The consultant sends information to contracted RN who completes the ILA and sends to the consultant within 10 days.
   e. The consultant then goes to see participant. This meeting takes place in the participant's home and at a time that is convenient for the participant. It may involve several support people for the participant.
   f. At that meeting:
      i. The consultant and the participant review the current ILA and determine whether it needs to be updated. The Consultant will send the information to the contracted RN from the Consultant agency who will update or perform a new assessment as indicated by that review.
      ii. The consultant establishes an allowance amount (see "The Allowance" below) based either on the current service plan or revised assessment.
      iii. The participant and consultant start the budget development process (see "The Budget" below).
      iv. The participant completes the Flexible Choices Informed Consent Form (CFC 832), allowance form (CFC 836), and budget form. The consultant and the participant sign an approved budget using the Budget Form (CFC 835). These forms are to be signed by the participant or legal guardian. A Power of Attorney may sign only if participant is unable to sign for him/herself.

   g. The consultant sends a copy of the Informed Consent Form (CFC 832), the ILA, and the Allowance Approval Form (CFC836) to the regional Long Term Care

Clinical Coordinator for utilization review and approval within 14 days of receiving the LTCCC Clinical Certification.

h. The Long Term Care Clinical Coordinator returns the approved allowance to the consultant and the participant once DCF has completed the financial eligibility.
i. The consultant forwards the completed budget and allowance form with a start date to Fiscal ISO, and the participant with a start date for services.
j. The consultant, working with the participant, sends the Notice of Start of Services through Flexible Choices Option (CFC 833) and the Notice of Stop of Services through Flexible Choices Option (CFC 834) to the necessary service providers.
k. There is no limit to how often a participant may access the services of their consultant.

2. Initiation of FC for current CFC participants: A participant begins receiving service in the Flexible Choices option through the following process:

   a. The participant indicates his or her interest in Flexible Choices by completing a copy of the Flexible Choices Referral Form (CFC 831) and sending it to the Flexible Choices coordinator. The referral form includes consent for the consultant to talk to the case management agency, Adult Day provider, DAIL, and the Fiscal ISO. Participants may get a copy of this form either from the consultant agency, their case manager, the regional Long Term Care Clinical Coordinator (LTCCC), or online.
   b. The consultant makes contact with the participant within two working days of the receipt of the referral form.
   c. The consultant will send out a copy of the Welcome Letter, Self-Screening Form, Welcome to Flexible Choices booklet, Flexible Choices brochure, Rewarding Work brochure, Referral form (if not sent already).
   d. The consultant contacts the participant's current case manager and confirms that the participant is a participant or surrogate directed participant in Choices for Care and requests a copy of the Independent Living Assessment (ILA), the personal care worksheet and the Service Plan including the Emergency Contacts and Back-up Plan.
   e. The case manager sends this information within five working days of the request. The case management agency is also expected to share with the consultant participant information that will assist them in the completion of an appropriate budget for the participant.
   f. The consultant contacts the participant to set up an initial care plan meeting with the participant within three working days of receipt of the material from the case management agency. This meeting takes place in the participant's home and at a time that is convenient for the participant. It may involve several support people for the participant.
   g. At that meeting:
      i. The consultant and the participant review the current ILA and determine whether it needs to be updated. The Consultant will send the information to the contracted RN who will update or perform a new assessment as indicated by that review.

ii. The consultant establishes an allowance amount (see "The Allowance" below) based either on the current service plan or revised assessment.
iii. The participant and consultant start the budget development process (see "The Budget" below).
iv. The participant completes the Flexible Choices Informed Consent Form (CFC 832), allowance form (CFC 836), and budget form. The consultant and the participant sign an approved budget using the Budget Form (CFC 835).

h. The consultant sends a copy of any revised or new assessment information, budget form (CFC 835), and the Allowance Approval Form (CFC836) to the regional LTCCC for utilization review and approval.
i. The LTCCC returns the approved allowance to the consultant and the participant.
j. The consultant forwards the completed budget and allowance form with a start date to Fiscal ISO, and the participant with a start date for services.
k. The consultant, working with the participant, sends the Notice of Start of Services through Flexible Choices Option (CFC 833) and the Notice of Stop of Services through Flexible Choices Option (CFC 834) to the necessary service providers.

D. Nursing Facility Setting

1. If the nursing facility provider believes that the applicant may meet CFC, Long-Term Care Medicaid financial eligibility criteria, services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) "Clinical Certification" is made, with a mutual agreement between the provider and the individual or legal representative.

2. The nursing facility provider shall inform individuals that, by starting services in advance of final CFC eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible for CFC services.

3. In the event that there is a question regarding the individual's potential CFC financial eligibility, the nursing facility provider may delay the initiation of CFC services until the Department for Children and Families (DCF) has determined CFC financial eligibility and DAIL has authorized the Service Plan.

4. The nursing facility provider may not bill the State for CFC services provided until DCF has approved financial eligibility and DAIL has authorized the CFC Service Plan.

5. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the nursing facility provider may bill the individual for services provided as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

SECTION V.7. Denial and Termination Procedures

A. Voluntary Withdrawal

An applicant may voluntarily withdraw her/his application for Choices for Care (CFC) services or participation in CFC services at any time for any reason using the following procedures:

1. The individual shall inform the case manager, provider, DAIL or DCF staff of his/her decision to withdraw the CFC application or services.

2. When an individual informs a case manager or provider, a "Change Report" form must be completed and sent to DAIL and DCF indicating the reason for termination and that it is a voluntary withdrawal.

   a. The case manager completes the "Change Report" form for home-based and ERC setting.
   b. The nursing facility provider completes the "Change Report" form for nursing facility setting.

3. If the individual informs DAIL staff of his/her decision to withdrawal the CFC application or services, DAIL staff will send the individual a "Change Report" to complete and sign and mail back. If this form is not mailed back within 11 days of receipt of the notification, then the individuals' application will be closed by DAIL staff. DAIL staff will notify DCF staff of the closure.

4. If the individual informs DCF staff of his/her decision to withdrawal the CFC application or services, DCF staff will notify DAIL staff and will send the individual a notice to confirm the withdrawal.

B. Denials and Terminations

New applicants may be denied eligibility and active participants may be terminated from CFC services for the following reasons:

1. Clinical ineligibility: The Department of Disabilities, Aging and Independent Living (DAIL) staff will determine clinical eligibility. If found ineligible at any time, DAIL staff will send a written notice of ineligibility to the individual and DCF with appeal rights.

2. Financial ineligibility: The Department for Children and Families Economic Services Division (DCF-ESD) staff will determine financial eligibility. If the individual is found financially ineligible at any time, DCF will send a written notice of ineligibility to the individual and DAIL staff, including appeal rights.

3. Participant death: If the individual dies, a "Change Report" form must be completed and sent to DAIL and DCF.

a. The case manager completes the form for the Home-Based, Adult Family Care and Enhanced Residential Care (ERC) setting.
b. The nursing facility provider completes the form for nursing facility setting.

4. Permanent move out of state: If the individual permanently moves out of the state, a "Change Report" form must be completed and sent to DAIL and DCF. **DAIL staff** will send a written notice of ineligibility with appeal rights to the individual and DCF if the denial or termination is involuntary.
   a. The case manager completes the "Change Report" form for home-based and ERC setting.
   b. The nursing facility provider completes the "Change Report" form for nursing facility setting.

5. Stay out of state-exceeding 30 continuous days: If the individual leaves the state for more than 30 continuous days, a "Change Report" form must be completed and sent to DAIL and DCF. DAIL staff will send a written notice of ineligibility with appeal rights to the individual and DCF if the denial or termination is involuntary.
   a. The case manager completes the "Change Report" form for home-based and ERC setting.
   b. The nursing facility provider completes the "Change Report" form for nursing facility setting.

6. The individual no longer requires CFC services to remain in setting of choice: If the case manager or provider(s) has evidence which leads him or her to believe that the individual no longer requires CFC services to remain in the setting of their choice, a "Change Report" form must be completed and sent to DAIL and DCF. **DAIL staff** will send a written notice of ineligibility with appeal rights to the individual and DCF if the denial or termination is involuntary.
   a. The case manager completes the "Change Report" form for Home-Based, Adult Family Care and ERC setting.
   b. The nursing facility provider completes the "Change Report" form for nursing facility setting.

7. Provider termination of services: In limited situations, a CFC **provider** may terminate services for the following reasons:
   a. Non-payment of patient share by the individual or legal representative.
   b. Dangerous environment placing staff at risk of physical harm.
   c. Involuntary discharge from residential setting (ERC or nursing facility) according to DLP Licensing Regulations. *This does not include a voluntary transfer of setting within CFC services.*
   d. Participant moves from AFC Home see Section V.7 #8 below.

   It is expected that the provider will make all reasonable attempts to remedy the situation prior to termination of services. Efforts may include, but are not limited to, negotiated risk contracts, involvement of Adult Protective Services, family care conferences, and interdisciplinary team meetings. Efforts must be clearly documented and the provider must contact DAIL staff and the case manager (when applicable),

prior to termination. Once a decision to terminate services has been made, the provider must send a written notice to the individual explaining the reasons for termination. Licensed facilities (ERC and NF) must follow existing regulations regarding discharge notices.

If the provider has terminated services, the situation is not remedied after 30 days, and other CFC services are not being successfully utilized, the individual may be terminated from CFC services. The provider must consult with DAIL staff prior to termination. A "Change Report" from must be completed and sent to DAIL. DAIL staff will send a written notice with appeal rights to the individual and DCF if the denial or termination is involuntary.

a. The case manager completes the "Change Report" form for home-based and ERC setting.

b. The nursing facility provider completes the "Change Report" form for nursing facility setting.

8. Adult Family Care Home Moves:

A. Voluntary move from an AFC Home.

a. Participants (or legal representative) who wish to move, must give at least a 30-day notice to the AFC Home provider (according to the Live-In Agreement), unless otherwise agreed upon by both the participant (and legal representative) and AFC Home provider.

b. Participants (or legal representative) must be included in the decision-making process with the Authorized Agency and AFC home concerning the selection of an alternative placement if applicable.

B. Involuntary move from an AFC Home.

The AFC home or Authorized Agency may initiate a move under the following circumstances:

a. The participant presents a serious threat to self that cannot be resolved through person centered care planning and the participant is incapable of engaging in a negotiated risk agreement;
b. The participant presents a serious threat to other residents of the home or staff that cannot be managed through interventions, person centered care planning or negotiated risk agreements;
c. A court has ordered the move;
d. The participant/legal representative failed to pay room & board in accordance with the live-in agreement;

e. The participant/legal representative refuses to abide by the terms of the live-in agreement; or
f. If the AFC Home provider can no longer meet the participant's needs as identified in the person centered care plan and according to the contract with the Authorized Agency.

C. Emergency move from an AFC Home.

An emergency move may be made with less than 30-day notice under the following circumstances:

a. An emergency move from the AFC Home is necessary for the health and safety of the participant or other residents and the participant's attending physician, Authorized Agency and Case Manager have documented the specific circumstances.

b. A natural disaster or emergency necessitates the evacuation of individuals from the home; or

c. When ordered or permitted by a court.

The Authorized Agency, AFC Home provider and Case Manager must include the participant (and legal representative) in the decision-making process concerning any move and the selection of a new home provider or other placement. The participant (or legal representative) must be offered a referral to the Long-Term Care Ombudsman program when the participant (or legal representative) is not initiating the move.

The Authorized Agency, AFC Home Provider and Case Manager will make all reasonable attempts to remedy a situation prior to an involuntary move. Efforts may include, but are not limited to, negotiated risk contracts, involvement of Adult Protective Services, family care conferences, and interdisciplinary team meetings. Efforts must be clearly documented and the Authorized Agency must contact DAIL staff and the case manager (when applicable), prior to termination. Once a decision to terminate services has been made, the provider must send a written notice to the individual explaining the reasons for termination.

If the AFC Home provider has initiated the move and the situation is not remedied after 30 days, and other CFC services are not being successfully utilized, the individual may be terminated from CFC services. The Authorized Agency must consult with the individual, DAIL staff and the case manager prior to a CFC termination. A "Change Report" from must be completed by the case manager and sent to DAIL. DAIL staff will send a written notice with appeal rights to the individual and DCF if the CFC denial or termination is involuntary.

SECTION V.8. Notices, Variances & Appeals Procedures

I. Notice

A. When the **Department of Disabilities, Aging and Independent Living** (DAIL) makes a decision regarding an applicant or participant's eligibility, type or amount of services authorized, or variance request, a written notice of the decision shall be sent.

B. The written notice of decision shall include:

1. The basis for the decision;
2. The legal authority for the decision;
3. The right to request a variance;
4. The right to appeal; and
5. Information on how to file an appeal.

II. Provider Responsibilities

Agencies, organizations, and individuals who provide Choices for Care services shall abide by applicable laws, regulations, policies and procedures. **DAIL** may terminate the provider status of an agency, organization, or individual that fails to do so.

III. Variances

A. **DAIL** may grant variances to the Choices for Care regulations.

B. Variances may be granted upon determination that:

1. The variance will otherwise meet the goals of the Choices for Care waiver; and

2. The variance is necessary to protect or maintain the health, safety or welfare of the individual.

3. Applicants, participants, and providers may submit requests for a variance to the DAIL at any time.

4. Variance requests shall be submitted in writing, and shall include:

    a. A description of the individual's specific unmet need(s);
    b. An explanation of why the unmet need(s) cannot be met; and
    c. A description of the actual/immediate risk posed to the individual's health, safety or welfare.

5. In making a decision regarding a variance request, DAIL may require further information and documentation to be submitted. DAIL also may require an in-home visit by DAIL staff. DAIL shall review a variance request and forward a

decision to the individual, his or her legal representative, if applicable, and to the provider(s).

6. DAIL shall make a decision regarding a variance request within thirty (30) days of receiving the request and shall send written notice of the decision, with appeal rights, within thirty (30) days.

IV. Appeals

An applicant or participant (or legal representative) may appeal a decision made by the Department through a Commissioner's hearing, a fair hearing before the Human Services Board, or both. An appeal may be made to the Commissioner and the Human Services Board at the same time. An appeal may also be made to the Human Services Board following a Commissioner's hearing.

A. Commissioner's Hearing

1. An applicant or participant, or his or her legal representative, who wishes to appeal a decision regarding clinical eligibility, termination of eligibility, the type or amount of services authorized or a variance may request a formal review of that decision by the Commissioner of the Department.

2. The request for a Commissioner's hearing may be made orally or in writing, and shall be made within thirty (30) days of receiving written notice.

3. A request for a Commissioner's hearing shall be made by calling or writing to:

   Commissioner's Office
   Department of Disabilities, Aging & Independent Living
   103 South Main Street
   Waterbury, VT 05671
   802-241-2401

4. The Commissioner shall send written notice of the decision, with appeal rights, to the applicant or participant within thirty (30) days of the completion of the hearing.

B. Fair Hearing

An applicant or participant, or his or her legal representative, may file a request for a fair hearing with the Human Services Board. An opportunity for a fair hearing will be granted to any individual requesting a hearing because his or her claim for assistance, benefits or services is denied, or is not acted upon with reasonable promptness; or because the individual is aggrieved by any other Department action affecting his or her receipt of assistance, benefits or services; or because the individual is aggrieved by Department policy as it affects his or her situation. The Department shall respond to any clear indication (oral or written) that an applicant or participant wishes to appeal by

helping that person to submit a request for a hearing.

1. An applicant or participant, or his or her legal representative, who wishes to appeal a decision of the Commissioner or any decision regarding clinical eligibility, termination of eligibility, the type or amount of services authorized or a variance may request a fair hearing with the Human Services Board.

2. The request for a fair hearing must be made within ninety (90) days of receiving the written notice of determination or the written notice of the decision of the Commissioner.

3. A request for a fair hearing shall be made to:

   Human Services Board
   120 State Street
   Montpelier, VT 05620-4301
   802-828-2536

C. Continuation of Services Pending Appeal

1. Long-term care services shall not be provided to new applicants during the appeals process.

2. Long-term care services may continue to be provided to enrolled participants during the appeals process.

3. In order to continue to receive services, enrolled participants must request continued services when submitting the appeal. Choices for Care services shall be discontinued on the effective date of the decision unless the appeal is requested as of the effective date of the decision. In no event shall the effective date occur on a weekend or holiday.

4. Continuation of services does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require advance notice.

D. Adverse Action

When a DAIL decision will end or reduce the amount of services an individual has been receiving, the notice of decision shall be mailed at least eleven (11) days before the decision will take effect, except when:

1. DAIL has facts confirming the death of the individual;

2. DAIL has facts confirming that the individual has moved to another state;

3. DAIL has facts confirming that the individual has been granted Medicaid in

another State;

4. The individual has been admitted to a facility or program that renders the individual ineligible for services;

5. The Department receives a statement signed by an individual that states that he or she no longer wishes services; or

6. The individual's whereabouts are unknown and the post office returns agency mail directed to him or her indicating no forwarding address.

E. Financial Eligibility

Financial eligibility decisions or patient share determinations must be filed pursuant to DCF Medicaid regulations. If such an appeal is inadvertently submitted to the Department, it shall be forwarded to DCF as soon as possible.

SECTION V.9. Utilization Review Procedures

"Utilization Review" (UR) is a Department of Disabilities, Aging and Independent Living (DAIL) review process intended to assure that the Choices for Care (CFC) service type and volume are appropriate, person centered and meet the needs of eligible individuals in an efficient and effective manner. **DAIL staff** shall use the following procedures in completing utilization review.

A. Home-Based and Enhanced Residential Care (ERC) Setting

1. DAIL staff shall review documents for completeness (see application procedures, Section III for required forms) including all necessary signatures by the case manager, the Participant or legal representative and the surrogate (when applicable).

2. DAIL staff shall review the assessment information, with particular emphasis on health and functional needs.

3. DAIL staff shall review the proposed Service Plan, personal care worksheet (home-based), Tier worksheet (ERC), and service volume.

4. DAIL staff shall document any concerns or actions on a UR form, including conversations with case managers or providers.

5. DAIL staff shall follow-up with case managers or service providers regarding any questions or concerns.

6. DAIL staff shall consider variables such as, but not limited to:
   a. Health status of the individual
   b. Functional needs of the individual
   c. Total number of people living in the individual's household
   d. Size of the living environment
   e. Utilization of other CFC services (such as adult day in the home-based setting)
   f. Utilization of non-CFC services, including paid and unpaid help (such as Medicare home health services or family)
   g. Variance requests submitted by the case manager

7. DAIL staff shall make adjustments to the Service Plan, when appropriate, according to CFC eligibility requirements, and service principles, definitions, standards, and limitations.

8. DAIL staff shall notify the case manager when a Service Plan is being adjusted.

9. DAIL staff will send a copy of the adjusted Service Plan to the individual and providers, including appeal rights.

B. Nursing Facility Setting

Nursing facility services are provided as a bundled package to all eligible individuals. The daily rate for services is determined by the Division of Rate Setting, utilizing a case-mix method generated from the Minimum Data Set (MDS) tool.

The Department of Disabilities, Aging and Independent Living will conduct utilization review assessments on a case-by-case basis as needed, within the current state and federal regulations.

C. ACF Home-Based Setting

1. DAIL staff shall review the AFC ILA for completeness.

2. DAIL staff shall review the AFC ILA assessment information, with particular emphasis on health and functional needs.

3. DAIL staff shall review the proposed AFC Tier worksheet to ensure the scores match the assessment information on the AFC ILA.

4. DAIL staff shall document any concerns or actions on a UR form, including conversations with case managers or providers.

5. DAIL staff shall follow-up with case managers or service providers regarding any questions or concerns.

6. DAIL staff shall consider variables such as, but not limited to:
    a. Health status of the individual
    b. Functional needs of the individual
    c. Accuracy of assessment

7. DAIL staff shall notify the case manager of the AFC Tier.

SECTION V.10. Enrollment & Billing Procedures

A. Provider Enrollment

All Choices for Care and TBI providers must have approval from the Department of Disabilities, Aging and Independent Living (DAIL) before they can be enrolled as a Medicaid provider. Program enrollment is managed through the Adult Services Division (ASD). Each provider type has a different eligibility process as described in the ASD Provider Enrollment Process found on the ASD website.

1. The DAIL/ASD pre-application process requires that prospective providers complete an ASD provider enrollment application and attest that they have read, understand and will comply with:
   - (CFC) The Universal Provider Standards found in the Choices for Care High/Highest Program Manual online: http://asd.vermont.gov/resources/program-manuals
   - (CFC) The applicable service section of the Choices for Care High/Highest Program Manual. (link above)
   - The Medicaid rates for service specific revenue codes found in the rate table online. http://asd.vermont.gov/resources/rates
   - The Medicaid provider enrollment instructions found on the Vermont Medicaid Provider Portal. http://www.vtmedicaid.com/#/provEnrollInstructions
   - The Medicaid general provider agreement found on the VT Medicaid Provider Portal. http://www.vtmedicaid.com/#/provEnrollDataMaint
   - The Vermont Department of Vermont Health Access Program Integrity information regarding Medicaid fraud, waste and abuse. http://dvha.vermont.gov/for-providers/program-integrity

2. Fillable forms for consideration as a prospective CFC provider, are available on the ASD website and must be submitted with all required documentation to be considered for enrollment.

3. The CFC providers who have been approve by DAIL will be instructed to contact DXC to submit a Vermont Medicaid provider enrollment application. Call (802) 878-7871 or 1-800-925-1706 (toll free if you are calling in Vermont) or go to http://www.vtmedicaid.com/Downloads/forms.html.

6. DAIL will notify DXC when providers have been approved for enrollment as an approved CFC provider.

7. DXC Provider Enrollment and Recertification staff will assure that the provider has completed a Medicaid provider enrollment agreement, assign a provider number and confirm the provider's enrollment in writing to the provider.

B. Claims

1. CFC service providers shall only submit claims for Medicaid reimbursement for

services that have been provided to eligible participants in compliance with applicable service definitions, provider qualifications, and standards.

2. CFC service providers shall submit all claims for CFC services through Vermont's Medicaid Management Information System (MMIS), managed by Vermont's Medicaid fiscal intermediary, DXC in accordance with the Medicaid provider manual. All information about Medicaid claims submissions can be found on the Vermont Medicaid Portal.

3. CFC service providers shall submit claims using the correct revenue code, as listed in the ASD Medicaid Rate Table.

4. Questions about CFC service claims, payments, and claims procedures should be addressed to DXC (802-879-4450).

5. CFC service providers shall have mechanisms or procedures to assure that claims which are submitted are accurate, and in compliance with all applicable CFC procedures and regulations.

6. CFC service providers are responsible for preparing and submitting claims for services that they provide or are designated to manage no later than six months following the date of service.

7. Adult Family Care (revenue code 086) services and billing is managed by a DAIL approved "Authorized Agency" who manages and pays for the services provided within the DAIL authorized daily Tier Rate.
   a. The Authorized Agency maintains 5% of the Tier Rate for administrative fees.
   b. The Authorized Agency may bill up to 30 days at 94% of the Tier Rate while the participant is admitted to a hospital, for the purpose of providing services needed to the participant during an inpatient hospitalization stay. An inpatient hospitalization day is a day in which the participant is an admitted patient at the hospital and is still there at midnight. For example: If a person is admitted to the hospital at 10 a.m. on June 7th and they return home at 1 p.m. on June 10th, the Authorized Agency may bill up to 94% of the Tier Rate for dates of service June 7th, 8th and 9th. The Authorized Agency may bill 100% of the Tier Rate on June 10th. *Reference Adult Family Care Section IV.11 for details.*
   c. The AA may bill up to $35/day for pre-transition assessment, planning and matching services for up to 60 non-consecutive days prior to the date of transition into the AFC home for eligible CFC participants. The eligible start for billing pre-transition services begins no earlier than the date the AA has notified the DAIL Long-Term Care Clinical Coordinator that the participant and AA have an agreement to start AFC services.

8. Participant-Directed and Surrogate-Directed Services (revenue codes 071, 075, 077, 080, 081) are provided by workers employed by the Participant or surrogate employer. Services shall be billed through an intermediary service organization (ISO) which is a payroll agent for Participant employers and surrogate employers.

9. Home-Based Waiver Assistive Devices and Modifications (revenue code 076) services may be provided by a variety of organizations or individuals. Services shall be billed through the individual's case management agency. When needed, items may be purchased and claims paid

prior to discharge from a nursing home, as long as there is an active discharge plan in place.

The following billing dates are to be used:

a. Assistive Devices: The billing date (date of service) will always be the date the item was received by the individual.
b. Home Modifications: The billing date (date of service) will always be the date the home modification work was completed.
c. Loans/Payment plans: The billing date (date of service) will always be the date the payment is made to the service provider as part of a payment plan established by the case manager in advance.

10. The Service Plan must be approved by DAIL and received by the service provider before any claims for CFC services may be submitted to the HP Medicaid claims processing system. Providers enrolled in using SAMS may utilize the SAMS Care Plan tool as DAIL authorization.

11. CFC service providers must obtain and retain copies of the approved Service Plan for every waiver participant to whom waiver services are provided. The approved Service Plan specifies the type, frequency and volume of CFC services, as well as the start date and end date of approval. Only claims for services that comply with the details and limitations of the approved Service Plan may be submitted to the Medicaid claims processing system.

12. **DAIL** will consider retroactive requests for Service Plan increases (HB & ERC) only under certain circumstances when a precipitating event necessitates an immediate increase of services exceeding the currently approved volume of services.
    a. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing home placement. For example: The home-based primary caregiver is hospitalized or the individual has a medical event that requires immediate increase in services.
    b. Retroactive Service Plan changes will not be approved to cover administrative errors or non-emergent requests for increases.
    c. All requests for retroactive coverage must accompany a Service Plan change, a written request for a specific start date and a description of the precipitating event.
    d. The effective date of the change or changes shall be no greater than six months proceeding the date that the request is received by DAIL.

13. If a CFC service provider submits any claims for services that exceed the dates, types and/or amounts of services that are authorized by an approved Service Plan, the service provider must arrange recoupment (or re-payment) to DXC of all payments for services that exceed the dates, types and/or amounts authorized.

14. If a CFC service provider submits any claims for any waiver services which exceed the types and amounts of services actually provided to an eligible individual (but are within the dates, types and amounts of services which are authorized by an approved Plan of Care), the service provider must arrange recoupment (or re-payment) to DXC of all payments for services which exceed the amount actually provided.

15. Case Management services (revenue code 070) may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing home or hospital, when such services are clearly documented as facilitating the individual's return to the community.

16. Case Management services claims (revenue code 070) that exceed the billing cap of 48 hours per calendar per person must be submitted with a copy of the applicable DAIL variance approval letter.

17. Enhanced Residential Care (ERC) and Assistive Community Care Services (ACCS) shall submit claims for days the participant in the in home. This is determined by where the participant is at midnight on the date of service. A date of service = 12:01am-12:00am (midnight). For example: If a person is admitted at 1 p.m. to the hospital on 6/10/13 and returns to the home at 10 a.m. 6/12/13, the home shall not submit an ERC or ACCS claim for 6/10/13 and 6/11/13. However, the home will submit a claim for the day before admission (6/9/13) and the date the person returns to the home (6/12/13).

18. Hourly services must be rounded to the nearest 15-minute billing unit for all approved activities provided on the same date of service.

    Example #1: If case management services provided to a person on 6/20/13 included 40 minute round-trip drive to the participant's home, 45 minute home visit, and 3 minute review and response to an email from a provider, the total minutes for that day equals 88 minutes, which rounds to 1.5 hours or six (6) 15-minute billing units.
    Example #2: If case management services provided to the same person on 7/1/13 included a 5 minute phone call, a 2 minute email and a 1 minute phone message the total billable time for 7/1/13 is 8 minutes, or one (1) 15-minute billing unit.
    Example #3: If a home health personal care attendant provided 2.5 hours (150 minutes) of personal care in the morning and a second attendant provides 3 hours and 25 minutes (205 minutes) in the afternoon to the same person. The total rounded billable time for that person on that date of service is 6 hours or 24 billing units.

C. Medicaid Fraud & Abuse

The Department of Vermont Health Access (DVHA) Program Integrity (PI) Unit strives to ensure that Medicaid funds are utilized appropriately through the identification and reduction of Medicaid fraud, waste and abuse. Quality control measures designed to help control rising costs of health care and protect diminishing state resources help protect the integrity of Vermont's Medicaid program through the elimination of beneficiary and provider fraud, waste and abuse. For more information or to report suspected healthcare fraud or abuse, go to http://dvha.vermont.gov/for-providers, call (802) 879-5900 or email ReportMedicaidFraud@state.vt.us.

D. Revenue Codes and Rates

As of July 2008, all Choices for Care billing revenue codes and rates are maintained and located in the **"ASD Services: Medicaid Claims Codes and Reimbursement Rates"** table. The table is found on the ASD website one the Medicaid Services Rate page.

E. Claims Resolutions

Medicaid providers must take the following steps to resolve any unpaid Medicaid claims.

1. Verify the participant's health care eligibility using one of the HP verification systems. See the DXC provider billing manual for instructions or go to http://www.vtmedicaid.com/#/home. Eligibility must be verified before providing services or submitting claims. Do not submit claims if eligibility has not been verified as approved.

2. For long-term care **Choices for Care** (CFC) claims – Verify that the CFC setting matches the service being provided for date of service you are billing for. You can do this through the DXC Help Desk/Malcolm voice response system: **In-state at 1-800-925-1706** or **out-of-state at 1-802-878-7871** ***Be sure to listen to the entire Malcolm message.***

3. If the Medicaid provider finds that there is no current CFC eligibility, services should not be provided or the Medicaid provider must provide written notification to the individual advising them they will be responsible to pay for the services if determined not eligible.

4. Before calling HP or any state office about a denied claim, providers have the following information ready:
    a. Name and date of birth of individual
    b. Social Security number
    c. Date claim submitted
    d. Remittance Advice (RA), Description of reason for claim denied on the RA (located on the last page), not just the denied number
    e. Type and date of service, e.g. case management for 12/3/12

5. If the provider has verified eligibility but the claim is denied for other reasons contact the HP help desk.

    DXC Help Desk in-state at 1-800-925 –1706
    Or
    DXC Help Desk out-of-state at 1-802-878-7871

    VT Medicaid Portal: http://www.vtmedicaid.com/#/home

SECTION V.11. Informed Consent and Negotiated Risk Procedures

A. Definitions

1. Self-determination is the right of every legally competent individual to make decisions regarding his or her own life, regardless of the nature of the decisions or the consequences to himself/herself.

2. Informed consent is the process in which a legally competent individual or his/her legal guardian is given the opportunity to make a fully informed decision regarding the individual's Choices for Care (CFC) services, using all information available that may influence that decision.

3. Negotiated risk is a process of negotiation which involves the individual or his/her legal guardian, case manager or flexible choices consultant and service provider(s), and which results in a formal written agreement. This process respects the individual's preferences, choices, and capabilities, and is designed to decrease the possibility that the individual's decisions or choices will place the individual or others at risk of significant harm.

4. Acceptable risk is the level of risk to an individual or his/her legal guardian is willing to accept after the informed consent process. Factors associated with risk to the individual may include, but are not limited to:
   - The individual's medical condition,
   - Behaviors,
   - Life style preferences,
   - Living environment,
   - Level of care needs, or
   - Refusal of services.

5. Risk of significant harm is the imminent or foreseeable (i.e. within the next 30 days) risk of death, serious or permanent injury, or illness serious enough to result in hospitalization.

B. Procedures

1. DAIL staff and all CFC providers shall support an individual's right to self-determination to the maximum extent possible and shall assist a participant in making decisions through informed consent.

2. Case managers and service providers shall support an individual's informed choice regarding life, liberty, and the pursuit of health and happiness, unless the participant's actions or decisions put other persons at risk of significant harm.

3. The individual has the right to receive services under conditions of acceptable risk in which the individual assumes the risk associated with decisions that he/she makes under conditions of informed consent.

4. If a CFC provider, or other concerned party believes that an individual is making decisions that put themselves or others at risk of significant harm, the provider shall confer with the individual's case manager (if applicable).

5. If the case manager believes that the individual has the capacity to understand the options available and the consequences of his/her decisions, and that others are not at risk, the case manager shall relay this information to the provider or concerned party. The concerns of others, along with the case manager's responses, shall be placed in the participant's case management record.

6. If the case manager questions the individual's ability to understand the consequences of decisions or choices and to give informed consent, the case manager must promptly assess the individual's mental status or arrange for a prompt assessment of the individual's mental status by a qualified medical professional or mental health professional.

7. Substantially impaired: If, after an assessment of the individual's mental status suggests the individual's capacity to understand the consequences of his/her decisions or choices is substantially impaired, and as a result the individual or others are at risk of significant harm, the case manager must take action to assure the protection of the health and welfare of the individual. Action steps may include the following:
   a. Review of the participant's status and situation with Medicaid Waiver team;
   b. Modification of the CFC Service Plan;
   c. Initiating proceedings to secure guardianship.

8. Not substantially impaired: If an assessment of the individual's mental status suggests the individual's capacity to understand the consequences of his/her decision or choices is NOT substantially impaired, but are still placing him/herself at significant risk of harm, the case manager shall review the individual's status and situation with the Medicaid Waiver team and service providers. The Medicaid Waiver team will review other services or actions, which may ameliorate the risk of harm, and present these to the individual.

9. Negotiated risk agreement: If the individual refuses other services or proposed actions, or risk of significant harm to him/her remains in spite of the services or actions taken, the case manager and/or provider(s) shall attempt to initiate a negotiated risk agreement. A negotiated risk agreement may only be utilized with an individual whose capacity to understand the consequences of his/her decision is not substantially impaired or his/her legal guardian. The written negotiated risk agreement shall include:
   a. A description of the individual's needs, including a description of those needs which cannot be met;

b. A description of the services which can be provided or will not reduce the risk;
c. A description of the potential risks to the individual;
d. A statement that other service options have been explained to the individual (or legal guardian), and that the individual (or legal guardian) understands and accepts the risks associated with the current plan; and
e. Signatures of the individual (or legal guardian), case manager, and relevant other parties.

10. If a negotiated risk agreement is created, a copy of the agreement shall be given to the individual, case manager and applicable service providers. A copy of the agreement shall be placed in the individual's case management record.

11. Others at risk of harm: If the assessment reveals that the individual is able to understand the consequences of her/his decisions, but is putting other persons at risk of significant harm, the case manager and the local waiver team shall consider involuntary termination of services (*See Denials and Terminations*). The provider(s) shall follow internal protocol relative to the situation. When appropriate, referrals shall be made to other professionals, such as, but not limited to, local police, Adult Protective Services, mental health services, etc.

12. When disagreement exists among the case manager, providers and/or members of the Medicaid Waiver Team, the case manager shall request technical assistance from the Department of Disabilities, Aging and Independent Living (DAIL).

13. Guardianship: Any person who believes that a participant is not able to understand the consequences of his/her decisions, or that an individual cannot provide informed consent due to a mental or cognitive impairment, may initiate a petition for guardianship through the local probate court at any time.

14. Abuse, neglect or exploitation: Pursuant to Vermont statute 33 V.S.A. § 6903, all Long-Term Care service providers are mandated reporters. If at any time, the case manager or provider(s) suspects the individual's health and welfare is a risk due to the action of another person (legal guardian, family, friends, provider, etc.), the case manager or provider(s) must report to the Department of Disabilities, Aging and Independent Living, Division of Adult Protective Services at 1-800-564-1612.

Section V.12. Medicare Advocacy Project (MAP) Procedures

The purpose of the Medicare Advocacy Project procedures is to insure full utilization of Medicare nursing facility benefits.

1. New applicants, who require Choices for Care (CFC), VT Long-Term Care Medicaid as a payer source for nursing facility care, will be referred to the Department of Disabilities, Aging and Independent Living (DAIL).

2. DAIL staff determines clinical eligibility and completes the Clinical Certification form (CFC form 803) including hospital admission and payer source information.

3. DAIL staff sends a copy of the Clinical Certification form to the Department for Children and Families (DCF).

4. When an active CFC nursing facility resident has readmission from a hospital the nursing facility provider submits a Change Report Form (CFC 804B) DCF and DVHA. Changes include:
   a. Re-admission from a three-day hospital stay,
   b. Change in payer source

5. DCF/Economic Services Division changes information on the LONG panel which is relayed to the HP system.

6. DVHA tracks to see if Economic Services Division information matches LONG panel in ACCESS system. If changes need to be made, DVHA will make those changes to the HP system.

7. DVHA will send the report to MAP in cases where an individual was admitted or readmitted to a nursing facility and who had a three-day hospital stay prior to the admission and who did not utilize the full 100 days of Medicare coverage.

8. MAP will verify with DVHA through ACCESS that the individual has Long-Term Care Medicaid coverage. MAP will follow up with a phone call to the nursing facility provider to confirm or clarify the information, as necessary. They will look to determine how many days of Medicare were used in this spell of illness.

9. After MAP verifies individual in a nursing facility who has had a three-day hospital stay and did not receive the full 100 days of Medicare and is on Long-Term Care Medicaid, MAP sends a letter to the individual and his/her patient representative which asks that the individual sign an authorization for MAP to represent the person in a Medicare appeal. Once the signed form is received, the appeal process is started.

NOTE: ***Utilization review of Medicare covered services by the Home Health Agencies will be done on a retrospective basis quarterly by MAP.***

SECTION V.13. Complaint Procedures

Complaints are a valuable aspect of quality improvement. Individuals have the right to make a complaint regarding any aspect of the Choices for Care (CFC), VT Long-Term Care Medicaid program.

In general, the Department of Disabilities, Aging and Independent Living (DAIL) encourages complaints and conflicts to be resolved at the local level whenever possible. Complaints may be made to DAIL verbally, by telephone, or in writing. DAIL staff will respond in a courteous, timely, and professional manner to all complaints, and will document all complaints which are referred to DAIL for resolution.

A. Procedures

All CFC provider agencies are required to have a complaint procedure that addresses how complaints will be collected and resolved internally. In general, the following procedures apply:

1. If a complaint arises, the individual or their case manager (if applicable) should be encouraged to contact the provider agency directly to resolve the issue.

2. If the individual is unable to resolve the issue, the individual or their case manager (if applicable) may contact the Department of Disabilities, Aging and Independent Living (DAIL).

3. DAIL staff shall document the complaint and discuss possible means of addressing the complaint with the individual, their case manager (if applicable), and the person/provider against whom the complaint was made.

4. DAIL staff shall document any actions, investigations, and/or results associated with the complaint.

5. DAIL staff will send a brief written summary of the result of the investigation to the complainant.

6. DAIL staff will send a written summary of the result of the investigation to the person/provider against whom the complaint was made. This shall include a plan of correction if necessary.

B. Long-Term Care Ombudsman

The Vermont Long-Term Care Ombudsman Program helps resolve complaints for individuals residing in licensed nursing facilities, residential care homes, assisted living residences, and Choices for Care participants. Individuals, case managers and providers may contact the Ombudsman by calling Vermont Legal Aid at 1-800-917-7787.

C. Division of Licensing and Protection (DLP)

DAIL staff shall forward the following types of complaints to the Division of Licensing and Protection for investigation and resolution:

1. Suspicion of Abuse, Neglect or Exploitation shall be forwarded to Adult Protective Services within 48 hours. (800-564-1612 or 802-871-3317)

2. Issues related to Home Health Agency Medicare and Medicaid certification (i.e.: skilled nursing services, LNA, PT, OT, MSW).

3. Issues related to Nursing Facility, Residential Care Home, or Assisted Living Residence licensing regulations.

All mandated reporters are required by law to report suspected abuse, neglect of exploitation to DLP/APS.

Individuals, case managers or providers may contact DLP for assistance by calling (800)-564-1612 or 802-871-3317.

D. Medicaid Fraud

Medicaid fraud is committed when a Choices for Care (CFC), Long-Term Care Medicaid provider is untruthful regarding services provided to the participant in order to obtain improper payment. Medicaid fraud could also be committed by CFC a participant. The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit fraud against the Medicaid program.

Examples of Medicaid fraud include, but are not limited to:

1. Billing for services not actually provided (e.g. signing or submitting a timesheet for services which were not actually provided).

2. Billing for services provided by a different person (e.g. signing or submitting a timesheet for services provided by a different person).

3. Billing twice for the same service (e.g. signing or submitting a timesheet for services which were reimbursed by another source, or signing or submitting a duplicate timesheet for reimbursement from the same source).

DAIL staff shall refer suspected cases of Medicaid fraud to the Attorney General's Medicaid Fraud Control Unit for investigation and resolution. In addition, DAIL staff may also refer the case to the local police authorities for further investigation and possible prosecution.

Individuals, case managers or providers may contact the Medicaid Fraud unit for assistance by calling (802) 828-3171. Cases of suspected Medicaid fraud, waste or abuse

may also be referred to the Department of VT Health Access (DVHA) at (802) 879-5900 or http://dvha.vermont.gov/for-providers/program-integrity-reporting-suspected-fraud-waste-and-abuse.

SECTION V.14. Critical Incident Reporting

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

A. Definition

Critical Incident is a serious or severe situations in which:

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

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

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

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

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

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

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

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

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

4. **Medication Error**
   A medical error is a preventable adverse effect of care, whether or not it is evident or harmful to the person. This includes but is not limited to; administration of the wrong drug to the wrong person or in the wrong way or at the wrong time or wrong dose or wrong frequency or a missed dose. A participant's refusal to take a medication is not considered an error and should be documented in the person's record.

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

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

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

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

   "Restraint" includes:

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

performance when the medicine is not administered) by causing disorientation, confusion, or an impairment of physical or mental functioning.

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

10. **Untimely or Suspicious death**

D Agency/Provider Reporting Procedures & Timeframe

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

1. Any CFC service provider that becomes aware of a critical incident listed above is required to complete a critical incident report (CFC 831) and submit it to ASD, as soon as possible, and no later than **48 hours of discovery of the incident**.

2. Reports shall be faxed to ASD: 802-871-3052 or scanned and emailed to the ASD Critical Incident email address within 48 hours of incident discovery.

3. If the reporter cannot access a fax machine or email within 48 hours, they must call (802)-871-3035 as soon as possible (ASAP) **within 48 hours** of discovery of the incident. ASD staff will document the incident while speaking with the Reporter. If ASD is not available to answer the CIR call, (after regular business hours or on the weekend) the reporter shall leave a voicemail message including at least their name and contact information and the person(s) involved in the incident. The reporter must submit a written report as soon as possible after the phone call.

4. Adult Protective Services: Pursuant to Vermont statute 33 V.S.A. Chapter 69, all Choices for Care service providers are mandated to report suspicion of adult abuse, neglect and exploitation to the Division of Licensing and Protection (DLP), Adult Protective Services (APS) http://www.dlp.vermont.gov/protection. Mandated reporters are required to submit a critical incident report to the Adult Services Division AND report **within 48 hours to APS** by calling 1-800-564-1612 or out-of-state call (802) 871-3326 or online at http://www.dlp.vermont.gov/guidelines/report.

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

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

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

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

9. Licensed Providers: CFC providers that are licensed under the Vermont Home Health Agency Designation and Operation Regulations, Residential Care Home Licensing Regulations, Assisted Living Residence Licensing Regulations, and the Nursing Home Licensing and Operating Rule must also follow the applicable incident reporting criteria found in state regulation with the Division of Licensing and Protection http://www.dlp.vermont.gov/regs.

10. Internal Incident Reports: If the reporter works for an agency that has its own internal reporting requirement they must complete their internal process in addition to the ASD & APS reports.

E. DAIL/ASD Procedures & Timeframes:

1. When ASD receives an incident report during regular business hours, an ASD quality specialist will review the incident to determine if any action, remediation or improvement plan is needed and record the incident. ASD's follow-up response to each incident is based on multiple factors including but not limited to the individual's needs, the incident, actions taken and resolution to the incident.

2. When ASD quality specialist receives an incident report over the phone they will ask for all the information on Critical Incident Form (CFC 831).

   ASD quality specialist will review the incident information to determine:
   - If the incident meets the CIR definition
   - If the incident has been resolved
   - If the incident includes suspected abuse, neglect or exploitation
   - If the incident includes suspected Medicaid fraud or abuse
   - If appropriate actions were taken
   - If additional information is required
   - If investigation and remediation is required
   - If the report was made in the required timeframe
   - If there are any additional concerns triggered by the incident (trends)

3. ASD quality specialist will contact agencies, providers, family or appropriate authorities or emergency services for any incidents in which the CFC participant is still missing or in need of immediate assistance.

4. ASD quality specialist will submit a report to APS for all incidents that include suspected abuse, neglect or exploitation **within 48 hours**.

5. ASD quality specialist will report all incidents that include suspected Medicaid fraud or abuse to Department of Vermont Health Access (DVHA) Program Integrity (PI) Unit (802.879.5900) **within 72 hours** of discovery of the incident report.

6. ASD quality specialist will contact appropriate individuals or agencies for additional information as necessary. ASD quality specialist may request an internal investigation report from the provider. ASD quality specialist may conduct an investigation incorporating the following information:
   a. circumstances leading up to and culminating in the critical incident;
   b. any current practice, procedure or factor involved in providing the service that contributed to the occurrence of the critical incident;
   c. actions considered, developed or required as follow up to the critical incident

7. ASD Quality Specialist will review critical incident data to identify any repeat patterns, trends or concerns within **2 business days** of receipt of a report.
   a. If there is a concern, the ASD Quality Specialist will follow up with the ASD Quality Improvement (QI) committee within **2 business days**.
   b. The QI committee will review the information and determine if any actions are necessary within **2 business days** of receipt of the information.
   c. If deemed necessary by the ASD QI committee a Critical Incident Improvement Plan may be requested from the provider which may include:
      i. Actions to be taken to prevent reoccurrences or improve response in the event of similar incidents;
      ii. A date by which the actions will be taken;
      iii. The AA or provider agency staff responsible for taking the actions.
      iv. The ASD Quality Specialist will work in collaboration with the involved entities to ensure completion of a Critical Incident Improvement Plan.

8. ASD Quality Improvement Committee will conduct oversight of staff and providers to ensure critical incident reporting policies are being followed. Corrective action will be taken as needed to ensure these entities comply with critical incident reporting requirements.

SECTION V.15. Adult Family Care Disclosure of Information (DoI) Policy & Procedure

The Disclosure of Information (DoI) process applies to the Adult Family Care (AFC) option and is intended to assure that AFC Home Providers (Home Provider) and AFC respite workers receive relevant information so they can make an informed decision whether to agree to provide care in their own home to a Choices for Care AFC participant. The DoI form shall include relevant information about a person's current status and history of violent behaviors, any potential predictors of violent behavior and all medications they are taking. The information may only be disclosed with the participant or guardian's authorization.

1. The AA shall explain the purpose of the Disclosure of Information (DoI) notice to the participant and/or legal guardian.

2. In order to provide consent and sign a DoI form, the participant and/or guardian must be informed of all relevant facts and be deemed to possess sufficient mental capacity to understand and appreciate the nature and effect of the disclosure at the time of signing the form. If the participant does not have capacity to consent, participant's legal representative may provide consent on participant's behalf.

3. The AA shall complete the DoI form which must contain relevant information concerning the participant's history of violent behaviors and any potential predictors of violent behaviors.

4. If the participant or guardian declines to consent to the disclosure of any and all information deemed relevant or important, the DoI form shall reflect that the participant/guardian declined to consent to the disclosure.

5. After the participant or guardian consents or decline consent, the AA shall release the DoI information to the potential home provider and respite worker.

6. The Home Provider and respite worker shall include the information on the DoI or refusal to consent in their decision whether or not to agree to the placement or provide respite services.

7. The AA will maintain a copy of the consent in the participant's confidential file.

8. All providers shall maintain confidentiality with respect to any and all participant records, including the DoI Form.

SECTION V.16 ICD-10 Code Policy & Procedures

(For obtaining codes prior to October 1, 2015)

A. Policy

All Choices for Care (CFC) High/Highest participants must have a billable ICD-10 diagnosis code that relates to their need for long term services and supports.

The Case Manager, AFC Provider or ERC Provider shall obtain and record the ICD-9 and 10 codes on all Home based, Adult Family Care and Enhanced Residential Care service plans.

The Transition II Consultant or Nurse shall obtain and record the ICD-9 and 10 codes on the Allowance form for participants enrolled in the Flexible Choices option.

The DAIL LTCCC, at time of clinical assessment, shall obtain the ICD-9 and 10 codes from the nursing facility medical record and record it in the SAMS care plan.

B. Definition

ICD-10 replaces the ICD-9 code sets and includes updated medical terminology and classification of diseases.

ICD-10 codes are a method of coding an individual's state of health and institutional procedures. ICD-10 codes provide more information per code and provide better support for care management, quality measurement and analytics. There is an improved ability to understand risk and severity using these codes.

The detail captured by ICD-10 can facilitate patient care coordination across settings and improve public health reporting and tracking.

ICD-9 and 10 codes for the purpose of CFC must be related to the participant's need for long term services and supports. This means that the code must match or be closely related to the reason for CFC functional eligibility. Example: A participant with a long history of hypertension had a stroke with right sided paralysis. The client is clinically eligible for CFC due to the functional limitations resulting from the stroke. The accurate ICD code would be for stroke with right sided paralysis instead of hypertension.

ICD-9 code = 438.21 Late effects if cerebrovascular disease; hemiplegia affecting dominant side
ICD-10 code = I69.351 Hemiplegia/hemiparesis following cerebral infarction affecting right dominant side.

For more information visit the Centers for Medicare and Medicaid Services:
http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html?gclid=CjgKEAjwuMmdBRDljdfi2_qQpxkSJADDCRwsZRbXpYFzq0w33xl7g7OBDlyX3yJm02zF0tvFHERWZPD_BwE

C. Procedure

1. Home Based

Initial Service Plan for Traditional Home Based, Adult Family Care and Flexible Choices Allowance Procedure

A. The Case Manager, Consultant or AFC Provider will ensure that the current ICD-9 code relates to the individual's need for long term care and will use the code translator to obtain the ICD-10 code, if necessary.

The following sites may be used to look up codes:

- **ICD-9 Look up:** http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx
- **ICD-10 code look up**: http://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx
- **The following site may be used to translate codes from ICD-9 to ICD-10**: (This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) https://www.aapc.com/icd-10/codes/

B. If the Case Manager, Consultant or AFC Provider is unsure what diagnosis and ICD-9 and 10 code relates to the individual's need for long term care, then the Case Manager or Consultant shall contact the participant's primary care physician to obtain an ICD-9 and ICD-10 code that relates to their need for long term care and need for physical functional assistance. Some examples: Quadriplegia, Multiple Sclerosis, Muscular Dystrophy, Alzheimer's Dementia, Vascular Dementia etc. If the physician has an ICD-9 code, but no ICD-10 code, then the Case Manager or Consultant can use the ICD-10 code translator.

C. The Case Manager, Consultant or AFC Provider shall include the ICD-9 and ICD-10 code on the applicable service plan or allowance until the official change to ICD-10 on 10/1/15. After 10/1/15 only an ICD-10 code will be needed.

D. The DAIL LTCCC Nurse will enter the ICD-9 and 10 code into the SAMS database in the care plan when doing utilization review and processing the service plan or allowance authorization.

Reassessment/Change Service Plan for Traditional Home Based, Adult Family Care and Flexible Choices Allowance

A. If there has been change in an individual's diagnosis related to long term care at the time of reassessment or during a significant functional change, the Case Manager, Consultant or AFC Provider will ensure that the current ICD-9 code relates to the individual's need for long term care and will use the code translator to obtain the ICD-10 code.

The following sites may be used to look up codes:

- **ICD-9 Look up:** http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx
- **ICD-10 code look up**: http://www.cms.gov/medicare-coveragdatabase/staticpages/icd-10-code-lookup.aspx

*The following site may be used to **translate** codes from ICD-9 to ICD-10:*
(This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) https://www.aapc.com/icd-10/codes/

B. If the Case Manager, Consultant or AFC Provider is unsure what diagnosis and ICD-9 and 10 code relates to the individual's need for long term services and supports, then the Case Manager or Consultant shall contact the participant's primary care physician to obtain an ICD-9 and ICD-10 code that relates to their need for long term care and need for physical functional assistance. Some examples: Quadriplegia, Multiple Sclerosis, Muscular Dystrophy, Alzheimer's Dementia, Vascular Dementia etc. If the physician has an ICD-9 code, but no ICD-10 code, then the Case Manager or Consultant can use the ICD-10 code translator.

C. The Case Manage, Consultant or AFC Provider shall include the ICD-9 and ICD-10 code on the applicable service plan or allowance until the official change to ICD-10 on 10/1/15. After 10/1/15 only an ICD-10 code is necessary.

D. The DAIL LTCCC Nurse will enter the ICD-9 and 10 code into the SAMS database in the care plan when doing utilization review and processing the service plan or allowance authorization.

2. Enhanced Residential Care

Initial Service Plan

1. The ERC Provider shall ensure that the current ICD-9 code relates to the individual's need for long term services and supports and will use the code translator to obtain the ICD-10 code, if necessary.

The following sites may be used to look up codes:

- **ICD-9 Look up:** http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx
- **ICD-10 code look up**: http://www.cms.gov/medicare-coveragdatabase/staticpages/icd-10-code-lookup.aspx

*The following site may be used to **translate** codes from ICD-9 to ICD-10:*
(This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) https://www.aapc.com/icd-10/codes/

2. If the ERC Provider is unsure what diagnosis and ICD-9 and 10 code relates to the individual's need for long term services and supports, then the ERC Provider shall contact the participant's primary care physician to obtain an ICD-9 and 10 code that relates to their need for long term services and supports and need for physical functional assistance. Some examples: Quadriplegia, Multiple Sclerosis, Muscular Dystrophy, Alzheimer's Dementia, Vascular Dementia etc. If the physician has an ICD-9 code, but no ICD-10 code, then the ERC Provider can use the ICD-10 code translator.

3. The ERC Provider shall include the ICD-9 and ICD-10 code on the service plan until the official change to ICD-10 on 10/1/15. After 10/1/15 only an ICD-10 code is necessary.

4. The DAIL LTCCC Nurse will enter the ICD-9 and 10 code into the SAMS database in the care plan when doing utilization review and processing the service plan authorization.

Reassessment/Change

1. If there has been a change in an individual's diagnosis related to long term services and supports at the time of reassessment or during a significant functional change, the ERC Provider will ensure that the current ICD-9 and 10 codes relate to the individual's current need for long term services and supports and will use the code look up.

   The following sites may be used to look up codes:

   - **ICD-9 Look up:** http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx
   - **ICD-10 code look up**: http://www.cms.gov/medicare-coveragdatabase/staticpages/icd-10-code-lookup.aspx

   *The following site may be used to **translate** codes from ICD-9 to ICD-10:*
   (This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) https://www.aapc.com/icd-10/codes/

2. If the ERC Provider is unsure what diagnosis and ICD-9 and 10 codes relate to the individual's need for long term services and supports, then the ERC Provider shall contact the participant's primary care physician to obtain an ICD-9 and ICD-10 code that relates to their need for long term care and need for physical functional assistance. Some examples: Quadriplegia, Multiple Sclerosis, Muscular Dystrophy, Alzheimer's Dementia, Vascular Dementia etc. If the physician has an ICD-9 code, but no ICD-10 code, then the ERC Provider can use the ICD-10 code translator.

3. The ERC Provider shall include the ICD-9 and ICD-10 code on the service plan or allowance until the official change to ICD-10 on 10/1/15. After 10/1/15 only an ICD-10 code is necessary.

4. The DAIL LTCCC Nurse will enter the ICD-9 and ICD-10 code into the SAMS database

in the care plan when doing utilization review and processing the service plan authorization. .

3. Nursing Facility

Initial Assessment/Reassessment

1. At the time of clinical assessment, the DAIL LTCCC shall obtain the ICD-9 and 10 codes from the medical record.

2. If the ICD-10 code is not available, obtain the ICD-9 code that relates to their need for long term care and use the code translator to obtain the ICD-10 code.

   The following sites may be used to look up codes:

   - **ICD-9 Look up:** http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx
   - **ICD-10 code look up**: http://www.cms.gov/medicare-covdatabase/staticpages/icd-10-code-lookup.aspx

   *The following site may be used to **translate** codes from ICD-9 to ICD-10:*
   (This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) https://www.aapc.com/icd-10/codes/

3. The DAIL LTCCC Nurse will enter both the ICD-9 and ICD-10 code in the nursing facility care plan of the SAMS client record after the financial eligibility notice has been received.

Change of setting to another CFC Option

1. The Case Manager, Consultant, AFC or ERC Provider shall ensure that the current ICD-10 code continues to apply to the individual's need for long term services and supports at the time of the change of setting (CFC option) occurs..

2. If the ICD-10 code is not available, obtain the ICD-9 code that relates to their need for long term services and supports and use the code translator to obtain the ICD-10 code.

   The following sites may be used to look up codes:

   - **ICD-9 Look up:** http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx
   - **ICD-10 code look up**: http://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx

   *The following site may be used to **translate** codes from ICD-9 to ICD-10:*
   (This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) https://www.aapc.com/icd-10/codes/

3. The Case Manager, consultant, AFC or ERC Provider shall include the ICD-9 and10 code on the applicable service plan or allowance until the official change to ICD-10 on 10/1/15. After 10/1/15 only and ICD-10 code is necessary.

4. The DAIL LTCCC Nurse will enter the ICD-9 and 10 code into the SAMS database in the care plan when doing utilization review and processing the service plan or allowance authorization.

SECTION VI. Assessment Tools

An assessment is defined as a compressive, professional evaluation of an individual's circumstances, including but not limited to health, functional, social and financial needs.

A. Independent living Assessment (ILA)

The ILA is utilized for individuals residing in the home-based setting, Flexible Choices and Adult Family Care. A registered nurse must complete the Health Section of the ILA.

NOTE: *Refer to the ILA Manual for more detailed information.*

B. Resident Assessment (RA)

The RA is utilized for individuals residing in the Enhanced Residential Care (ERC) setting. The **ERC provider** is responsible for initiating and overseeing the completion of the RA.

NOTE: *Refer to RA Manual for more detailed information.*

C. Minimum Data Set (MDS)

The MDS is utilized for individuals residing in the nursing facility setting. The **nursing facility provider** is responsible for initiating and overseeing the completion of the MDS according to current state and federal regulation.

NOTE: *Refer to MDS Manual for more detailed information.*

D. Choices for Care Clinical Assessment

The Choices for Care Clinical Assessment is a health and functional assessment tool used by **Department of Disabilities, Aging and Independent Living (DAIL) staff** to assess CFC clinical eligibility.