VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

October 4th, 2016; 10:00 AM to 12:00 PM
AHS - WSOC Ash Conference Room, 280 State Drive, Waterbury, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:00 – 10:10	**Welcome & Introductions; Approval of Minutes** Deborah Lisi-Baker and Laural Ruggles	**Attachment 1:** August Meeting Minutes	Yes (approval of minutes)
2	10:10 – 10:30	**"Equity in Pregnancy Intention" (EPIC) Campaign to Reduce Unintended Pregnancy** Maura Graff, Planned Parenthood of Northern New England	**Attachment 2:** "EPIC" Overview **Attachment 2a:** "EPIC" One Page Summary **Attachment 2b:** Family Planning Referral Form	No
3	10:30 – 10:50	**Home and Community Based Rules Update** Megan Tierney-Ward and Roy Gerstenberger, Vermont Department of Disabilities, Aging and Independent Living	**Attachment 3:** Choices for Care, Application of Federal Rules Reference Table **Attachment 3a:** Choices for Care Work Plan **Attachment 3b:** Choices for Care, HCBS Alignment Report **Attachment 3c:** Developmental Disabilities Services Division HCBS Work Plan	No
4	10:50 - 11:35	**Population Health Plan Update** Heidi Klein, Vermont Department of Health	**Attachment 4:** Population Health Plan Presentation	No

			Full Population Health Plan available at: **http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont%20Population%20Health%20Plan%20-%20September%202016.pdf**	
5	11:35 – 11:50	**Practice Transformation Initiative Updates** Erin Flynn, Department of Vermont Health Access and Pat Jones, Green Mountain Care Board		No
6	11:50 – 12:00	**Wrap-Up and Next Steps; Plans for Final 2 Meetings**		No

Attachment 1 - 8-02-16 PT Meeting Minutes

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Vermont Health Care Innovation Project
Practice Transformation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, August 2, 2016, 10:00am-12:00pm, Oak Conference Room, Waterbury State Office Complex

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Laural Ruggles called the meeting to order at 10:01am. A roll call attendance was taken and a quorum was present. Dale Hackett moved to approve the May and June 2016 meeting minutes by exception. Susan Aranoff seconded. The minutes were approved with three abstentions (Molly Dugan – June; Jessa Barnard and Meg Burmeister – May and June). Georgia Maheras commented that a group from Myers & Stauffer, our SIM Sustainability Plan contractor, is sitting in on today's meeting.	
2. Medicaid Pathway Update	Selina Hickman provided an update on the Medicaid Pathway project (Attachment 2). • Medicaid Pathway bridges delivery system transformation (Vermont Model of Care), payment reform, a quality framework, and readiness, resources, and technical assistance. The key outcome: Is anyone better off? • The group discussed the following: • Dale Hackett asked how new payment models can impact social determinants that will improve population health. Selina replied that new payment models may allow providers (or groups of providers and other service providers working together) to address social and community needs. • Susan Aranoff noted that Medicaid Pathway and All-Payer Model project leaders are emphasizing provider-led reform, and commented that Medicare and CMS have historically been a strong force behind health care reform and that government is a critical partner in these reforms. Georgia Maheras noted that this emphasis came from Al Gobeille at the Green Mountain Care Board, and clarified that delivery system reforms should be provider-led but that government oversight is a critical function. Julie Tessler agreed that this is a collaborative process between government, payers, providers, and consumers.	

Agenda Item	Discussion	Next Steps
	• Dion LaShay commented that funding priorities and eligibility in the developmental services system requires individuals to be in crisis before they can receive services. Selina noted that this echoes comments in the Medicaid Pathway stakeholder group, and suggested that capitated or global models that incorporate risk can also allow providers flexibility to do things differently and provide services they may not otherwise have been able to provide/fund. • Julie Tessler commented that without additional resources within the DA/SSA system, the Pathway effort can't succeed. She suggested that reallocation of medical costs in community-based mental health and substance abuse services would help reduce system costs in other sectors, and added that peer support is a critical component of a successful model. • Dion LaShay asked whether Medicare is willing to partner in this area. Georgia replied that Medicare's willingness in this area has been limited, but she's heard that there may be some new Medicare-Medicaid partnerships coming out in the next few months. • Jessa Barnard asked where provider accountability would sit within the Pathway model (physical care practice vs. community based care practices). Selina replied that this work has focused on accountability for mental health, substance abuse, and developmental services at the community-based provider level. She added that there are various levels of integration that communities/regions could opt for; the State hasn't precluded physical-mental health integration at the provider level. • Beverly Boget commented that it seems like this project is attempting to capitate the community-based services sector, but suggested that savings are likely to occur in acute hospitalizations, ED visits, and other higher-cost settings. Selina replied that this is getting to total cost of care, and added that this is a question for the Legislature – are savings in acute care Vermont taxpayer savings, or should they be moved into other sectors? This group hasn't been able to answer these questions. Beverly replied that without investment in this sector, the model won't be successful; this provider sector has been historically under-resourced and doesn't have the ability to take on risk at the current resource level. Georgia Maheras added that AHS is required to submit a report to the Legislature on the Medicaid Pathway, and it will include findings on questions like this – this is a good opportunity to inform legislators of issues like these, since they manage appropriations. She also noted that incremental progress to better serve Vermonters is always worthwhile, and suggested interested parties participate in the formal information gathering process that will begin later this month. Selina added that this is not an academic exercise – we have demonstrated progress through Integrating Family Services, which has reorganized care without increased total dollars. • Susan Aranoff suggested adding a column to Slide 8 for payer risk under different models. • Julie Wasserman noted that savings on acute services may accrue to Medicare; others commented that savings may also accrue to other payers, depending on the insurance mix of individuals impacted by reforms. • Dale Hackett suggested adding a new measure: resource hours available. • Susan Aranoff suggested that on Slide 11, the State should be identified as a provider of key services to vulnerable populations in addition to a regulatory authority.	

Agenda Item	Discussion	Next Steps
	• Dale Hackett commented that providers can and do "prescribe" social and community services, but unless those services are available and individuals are connected to them, they are useless and individuals are unable to access benefits. Selina agreed that this is a challenge, and noted that a more integrated model where providers and services are co-located can provide closer connections. • Julie Tessler commented that Vermont Care Partners has worked quite a bit with this model, and suggested that provider-led, consumer and family-directed, and State-regulated were key aspects of the model, adding that the DAs and SSAs want to allow for integrated care within the system as well as more flexibility to provide preventive care and early intervention in partnership with other providers/services and the State. • Susan Aranoff suggested that information gathering around quality and outcomes should include consumers and include quality of life assessments and structured interviews to assess impact on individuals. Selina replied that there is a work group convened around quality and outcomes that includes each Department's quality representatives, as well as provider representatives and other private sector partners. • Sam Liss commented that person-centered care is highlighted throughout, and suggested this be broadened to person-directed care where appropriate throughout. He asked whether there are protections and safeguards throughout this model to ensure case management is conducted by the best possible provider, rather than an entity that is chosen for efficiency. • Erin Flynn commented that the work around shared care planning occurring through the Integrated Communities Care Management Learning Collaborative could be relevant to the quality and outcome measurement aspect of this work by identifying person-directed goals and indicating when they are met. Dale Hackett asked how we measure things that are not a benefit, and gave the example of wanting to attend a movie when the showing ends after the last bus is scheduled. He suggested public transportation is a potential measure for this. Selina commented that this is a proxy to get to issues of quality of life and community inclusion, but suggested that we need to pick the important measures that help us understand whether we were successful in achieving key outcomes, rather than just forcing providers to measure and report.	
3. Identifying and Addressing Practice Transformation Challenges and Barriers	Pat Jones and Erin Flynn led a discussion on identifying and addressing practice transformation challenges and barriers (Attachment 3). • Pat emphasized that care transformation is a key goal of payment models, and thanked this group and its co-chairs for many productive conversations over the past years. The group discussed the following: • Sam Liss asked whether anyone has done or will do an analysis of the contributions of employment, transportation, housing, or other services to social determinants of health. Pat replied that she can only respond anecdotally, but that one of the earliest Learning Collaborative interventions, the Camden Cards, have helped to identify needs like housing, transportation, community integration, and social interaction as key goals for individuals participating in care coordination. This has driven the kinds of organizations participating in care teams, and has been a change for many experienced care managers participating in the Learning Collaborative.	

Agenda Item	Discussion	Next Steps
	• Molly Dugan commented that shared care planning has been a critical tool for this. Laural Ruggles commented that the Community Connections program in St. Johnsbury has been working to meet individuals' social needs for years, and has encouraged collaborations between provider and social services organizations to meet these needs. Deborah Lisi-Baker added that PDSA cycles supports identification of state-level policy changes needed to expand effective interventions.	
4. Project Updates	*Integrated Communities Care Management Learning Collaborative*: Erin Flynn provided an update. • The next Learning Collaborative session will take place in September in Rutland and Waterbury, with a focus on 'Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations'. This learning session will discuss common care transitions and work together to identify data needed for successful care transitions, as well as collecting data at the point of care. There will also be a presentation on the OneCare Vermont Care Navigator pilot. Pat added that this is challenging work, and is individually focused. The eleven Learning Collaborative communities are working with over 200 individuals and their families around the State, exceeding expectations for the initiative, and partners are being trained on the Learning Collaborative tools around the State. Sarah Narkewicz and Sandy Knowlton-Soho have developed a "train-the-trainer" toolkit on their own, and these tools are reaching a new set of partners, including law enforcement and others. • A comprehensive toolkit will be posted to the VHCIP website in August, along with materials from Learning Sessions. Project Leadership is also working with OneCare Vermont to align with their care coordination toolkit. *Core Competency Training*: Erin Flynn provided an update. • Participants have received 5 (of 6 total) days of training; Day 5 took place in July, and a well-attended webinar also occurred in July. • A 2-day advanced care coordination training for staff working with individuals with mental health and substance abuse conditions and/or who are currently homeless, a training for managers and supervisors, and a "train-the-trainer" training, are upcoming. • Training materials are available on the VHCIP website.	
5. Wrap-Up and Next Steps; Plans for Next Meeting	Sam Liss commented that as of August 1, Medicaid for Working Persons with Disabilities enhancements were officially adopted in State policy; currently awaiting Federal approval, after which rulemaking will occur. **Next Meeting:** Tuesday, September 6, 2016, 10:00am-12:00pm, Oak Conference Room, Waterbury State Office Complex	

VHCIP Practice Transformation Work Group Member List

minutes MAY JUNE Dale 1° sue 2°

Member		Member Alternate				2-Aug-16
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff ✓	Bard	Hill			AHS - DAIL
		Clare	McFadden			AHS - DAIL
Abe	Berman	Sara	Barry ✓			OneCare Vermont
		Emily	Bartling			OneCare Vermont
		Maura	Crandall			OneCare Vermont
		Miriam	Sheehey			OneCare Vermont
Beverly	Boget ✓					VNAs of Vermont
Kathy	Brown	Stephen	Broer			DA - Northwest Counseling and Support Services
Barbara	Cimaglio					AHS - VDH
Michael	Counter					VNA & Hospice of VT & NH
Molly	Dugan ✓	Stefani	Hartsfield		A	Cathedral Square and SASH Program
		Klm	Fitzgerald			Cathedral Square and SASH Program
Eileen	Girling	Heather	Bollman			AHS - DVHA
		Jenney	Samuelson			AHS - DVHA - Blueprint
Maura	Graff					Planned Parenthood of Northern New England
Dale	Hackett ✓					Consumer Representative
Sarah	Jemley	Jane	Catton			Northwestern Medical Center
		Candace	Collins			Northwestern Medical Center
Linda	Johnson	Debra	Repice			MVP Health Care
Pat	Jones ✓	Kate	O'Neill ✓			GMCB
		Nancy	Breiden			VLA/Health Care Advocate Project
Dion	LaShay ✓					Consumer Representative

VHCIP Practice Transformation Work Group Member List

Minutes

Member		Member Alternate			2-Aug-16
First Name	Last Name	First Name	Last Name		Organization
Patricia	Launer	Kendall	West		Bi-State Primary Care
Sam	Liss				Statewide Independent Living Council
Deborah	Lisi-Baker				Consumer Representative
		Barbara	Prine		VLA/LTC Ombudsman Project
Kate	McIntosh	Judith	Franz		Vermont Information Technology Leaders
Bonnie	McKellar	Mark	Burke		Brattleboro Memorial Hopsital
Jessa	Barnard	Stephanie	Winters	A X	Vermont Medical Society
Mary	Moulton				VCP - Washington County Mental Health Services Inc.
Sarah	Narkewicz				Rutland Regional Medical Center
Jill	Olson	Mike	DelTrecco		Vermont Association of Hospital and Health Systems
Laural	Ruggles				Northeastern Vermont Regional Hospital
Catherine	Simonson				VCP - HowardCenter for Mental Health
Patricia	Singer	Jaskanwar	Batra		AHS - DMH
		Mourning	Fox		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
Shawn	Skafelstad	Julie	Wasserman		AHS - Central Office
Mary	Barmeister	Mike	Hall	A X	
Audrey-Ann	Spence				Blue Cross Blue Shield of Vermont

VHCIP Practice Transformation Work Group Member List

minutes

Member		Member Alternate			2-Aug-16
First Name	Last Name	First Name	Last Name		Organization
JoEllen	Tarallo-Falk				Center for Health and Learning
Julie	Tessler ✓				VCP - Vermont Council of Developmental and Mental Health Services
~~Lisa~~	~~Viles~~				Area Agency on Aging for Northeastern Vermont
Ben	Watts				AHS - DOC
	31 30		26		

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VHCIP Practice Transformation Work Group

Attendance Sheet

Tuesday, August 02, 2016

	First Name	Last Name	Organization	Practice Transformation
1	Nancy	Abernathy	Learning Collaborative Facilitator	X
2	Peter	Albert	Blue Cross Blue Shield of Vermont	X
3	Susan	Aranoff	AHS - DAIL	M
4	Debbie	Austin	AHS - DVHA	X
5	Ena	Backus	GMCB	X
6	Melissa	Bailey	AHS - DMH	X
7	Michael	Bailit	SOV Consultant - Bailit-Health Purchasing	X
8	Susan	Barrett	GMCB	X
9	Emily	Bartling	OneCare Vermont	MA
10	Jaskanwar	Batra	AHS - DMH	MA
11	Todd	Bauman	DA - Northwest Counseling and Support Ser	MA
12	Bob	Bick	DA - HowardCenter for Mental Health	X
13	Charlie	Biss	AHS - Central Office - IFS / Rep for AHS - DM	X
14	Beverly	Boget	VNAs of Vermont	M
15	Heather	Bollman	AHS - DVHA	MA
16	Mary Lou	Bolt	Rutland Regional Medical Center	X
17	Nancy	Breiden	VLA/Disability Law Project	MA
18	Stephen	Broer	VCP - Northwest Counseling and Support Se	M
19	Kathy	Brown	DA - Northwest Counseling and Support Ser	M
20	Martha	Buck	Vermont Association of Hospital and Health	A
21	Mark	Burke	Brattleboro Memorial Hopsital	MA
22	Anne	Burmeister	Planned Parenthood of Northern New Engl	X
23	Dr. Dee	Burroughs-Biron	AHS - DOC	X
24	Denise	Carpenter	Specialized Community Care	X
25	Jane	Catton	Northwestern Medical Center	MA
26	Alysia	Chapman	DA - HowardCenter for Mental Health	X

27	Joy	Chilton	Home Health and Hospice	X
28	Barbara	Cimaglio	AHS - VDH	M
29	Candace	Collins	Northwestern Medical Center	MA
30	Amy	Coonradt	AHS - DVHA	S
31	Alicia	Cooper	AHS - DVHA	S
32	Amy	Cooper	HealthFirst/Accountable Care Coalition of t	X
33	Michael	Counter	VNA & Hospice of VT & NH	M
34	Maura	Crandall	OneCare Vermont	MA
35	Claire	Crisman	Planned Parenthood of Northern New Engl	A
36	Diane	Cummings	AHS - Central Office	X
37	Dana	Demartino	Central Vermont Medical Center	X
38	Steve	Dickens	AHS - DAIL	X
39	Molly	Dugan here	Cathedral Square and SASH Program	M
40	Trudee	Ettlinger	AHS - DOC	X
41	Kim	Fitzgerald	Cathedral Square and SASH Program	MA
42	Erin	Flynn here	AHS - DVHA	S
43	Mourning	Fox	AHS - DMH	MA
44	Judith	Franz	Vermont Information Technology Leaders	MA
45	Mary	Fredette	The Gathering Place	X
46	Aaron	French	AHS - DVHA	X
47	Meagan	Gallagher	Planned Parenthood of Northern New Engl	X
48	Lucie	Garand	Downs Rachlin Martin PLLC	X
49	Christine	Geiler	GMCB	S
50	Eileen	Girling	AHS - DVHA	M
51	Steve	Gordon	Brattleboro Memorial Hopsital	X
52	Maura	Graff	Planned Parenthood of Northern New Engl	M
53	Dale	Hackett here	Consumer Representative	M
54	Samantha	Haley	AHS - DVHA	X
55	Mike	Hall	Champlain Valley Area Agency on Aging / C	MA
56	Stefani	Hartsfield	Cathedral Square	MA
57	Kathleen	Hentcy	AHS - DMH	MA
58	Selina	Hickman here	AHS - DVHA	X
59	Bard	Hill	AHS - DAIL	MA
60	Breena	Holmes	AHS - Central Office - IFS	X

61	Christine	Hughes	SOV Consultant - Bailit-Health Purchasing	S
62	Jay	Hughes	Medicity	X
63	Jeanne	Hutchins	UVM Center on Aging	X
64	Sarah	Jemley	Northwestern Medical Center	M
65	Linda	Johnson	MVP Health Care	M
66	Craig	Jones	AHS - DVHA - Blueprint	X
67	Pat	Jones	GMCB	M
68	Margaret	Joyal	Washington County Mental Health Services	X
69	Joelle	Judge	UMASS	S
70	Sarah	Kinsler	AHS - DVHA	S
71	Tony	Kramer	AHS - DVHA	X
72	Sara	Lane	AHS - DAIL	X
73	Kelly	Lange	Blue Cross Blue Shield of Vermont	X
74	Dion	LaShay	Consumer Representative	M
75	Patricia	Launer	Bi-State Primary Care	M
76	Deborah	Lisi-Baker	SOV - Consultant	C
77	Sam	Liss	Statewide Independent Living Council	M
78	Vicki	Loner	OneCare Vermont	M
79	Carole	Magoffin	AHS - DVHA	S
80	Georgia	Maheras	AOA	S
81	Carol	Maroni	Community Health Services of Lamoille Vall	X
82	David	Martini	AOA - DFR	X
83	John	Matulis		X
84	James	Mauro	Blue Cross Blue Shield of Vermont	X
85	Lisa	Maynes	Vermont Family Network	X
86	Clare	McFadden	AHS - DAIL	MA
87	Kate	McIntosh	Vermont Information Technology Leaders	M
88	Bonnie	McKellar	Brattleboro Memorial Hopsital	M
89	Elise	McKenna	AHS - DVHA - Blueprint	X
90	Jeanne	McLaughlin	VNAs of Vermont	X
91	Darcy	McPherson	AHS - DVHA	A
92	Monika	Morse		X
93	Judy	Morton	Mountain View Center	X
94	Mary	Moulton	VCP - Washington County Mental Health Se	M

95	Kirsten	Murphy	AHS - Central Office - DDC	MA
96	Reeva	Murphy	AHS - Central Office - IFS	X
97	Sarah	Narkewicz	Rutland Regional Medical Center	M
98	Floyd	Nease	AHS - Central Office	X
99	Nick	Nichols	AHS - DMH	X
100	Monica	Ogelby	AHS - VDH	X
101	Miki	Olszewski	AHS - DVHA - Blueprint	X
102	Jessica	Oski	Vermont Chiropractic Association	X
103	Ed	Paquin	Disability Rights Vermont	X
104	Eileen	Peltier	Central Vermont Community Land Trust	X
105	John	Pierce		X
106	Luann	Poirer	AHS - DVHA	S
107	Rebecca	Porter	AHS - VDH	X
108	Barbara	Prine	VLA/Disability Law Project	MA
109	Betty	Rambur	GMCB	X
110	Allan	Ramsay	GMCB	X
111	Paul	Reiss	HealthFirst/Accountable Care Coalition of t	X
112	Virginia	Renfrew	Zatz & Renfrew Consulting	X
113	Debra	Repice	MVP Health Care	MA
114	Julie	Riffon	North Country Hospital	X
115	Laural	Ruggles	Northeastern Vermont Regional Hospital	C
116	Bruce	Saffran	VPQHC - Learning Collaborative Facilitator	X
117	Jenney	Samuelson	AHS - DVHA - Blueprint	MA
118	Jessica	Sattler	Accountable Care Transitions, Inc.	X
119	Rachel	Seelig	VLA/Senior Citizens Law Project	X
120	Susan	Shane	OneCare Vermont	X
121	Maureen	Shattuck	Springfield Medical Care Systems	X
122	Julia	Shaw	VLA/Health Care Advocate Project	X
123	Miriam	Sheehey	OneCare Vermont	X
124	Catherine	Simonson	VCP - HowardCenter for Mental Health	M
125	Patricia	Singer	AHS - DMH	M
126	Shawn	Skaflestad	AHS - Central Office	M
127	Richard	Slusky	GMCB	X
128	Pam	Smart	Northern Vermont Regional Hospital	X

129	Lily	Sojourner	AHS - Central Office	X
130	Audrey-Ann	Spence	Blue Cross Blue Shield of Vermont	M
131	Holly	Stone	UMASS	S
132	Beth	Tanzman	AHS - DVHA - Blueprint	X
133	JoEllen	Tarallo-Falk	Center for Health and Learning	M
134	Julie	Tessler wre	VCP - Vermont Council of Developmental a	M
135	Bob	Thorn	DA - Counseling Services of Addison County	X
136	Win	Turner		X
137	Lisa	Viles	Area Agency on Aging for Northeastern Ver	MA
138	Beth	Waldman	SOV Consultant - Bailit-Health Purchasing	X
139	Marlys	Waller	DA - Vermont Council of Developmental an	X
140	Nancy	Warner	COVE	X
141	Julie	Wasserman wre	AHS - Central Office	S/MA
142	Ben	Watts	AHS - DOC	X
143	Kendall	West phone	Bi-State Primary Care/CHAC	MA
144	James	Westrich	AHS - DVHA	S
145	Robert	Wheeler	Blue Cross Blue Shield of Vermont	X
146	Jason	Williams	UVM Medical Center	X
147	Stephanie	Winters	Vermont Medical Society	MA
148	Jason	Wolstenholme	Vermont Chiropractic Association	X
149	Mark	Young		X
150	Marie	Zura	DA - HowardCenter for Mental Health	X
				150

Julie Corwin - DVHA
Sara Barry - OneCare Vermont
Jessa Barnard - VMS
Meg Burmeister - AAA
Kate O'Neill - GMCB

Attachment 2 - EPIC Overview

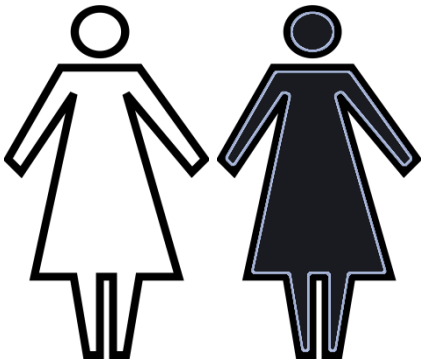
An EPIC Vision to Reduce Unintended Pregnancy

Maura Graff, MPH, Project Director

Planned Parenthood® of Northern New England

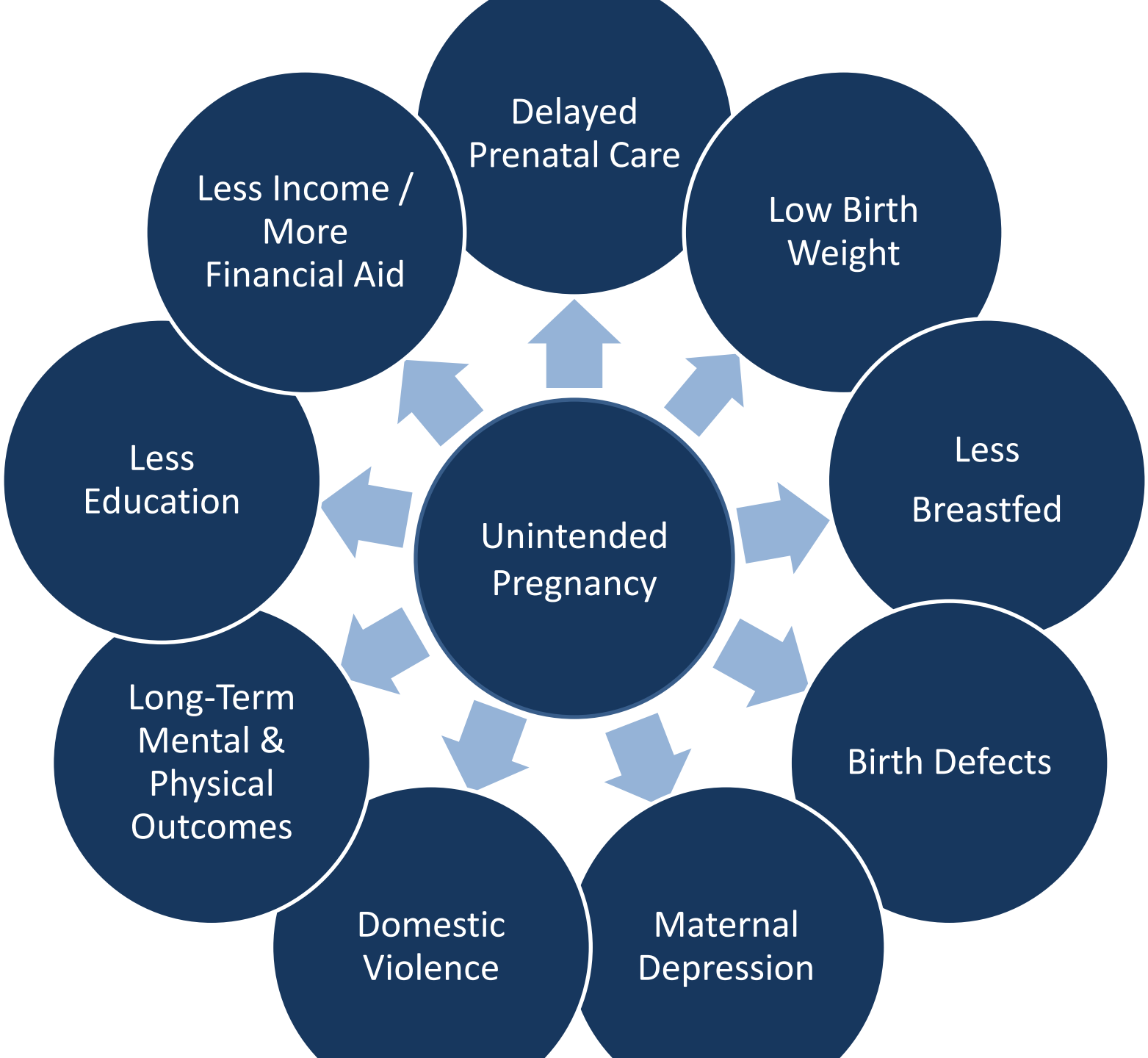
4 October 2016

ACA	Affordable Care Act
ACO	Accountable Care Organization
EPIC	Equity in Pregnancy Intention Campaign
FP	Family Planning
IUD	Intrauterine Device
LARC	Long Acting Reversible Contraception
NFP	Nurse Family Partnership
PPNNE	Planned Parenthood of Northern New England
VDH	Vermont Department of Health



In Vermont

half of all pregnancies are unintended.


Delayed Prenatal Care
Low Birth Weight
Less Breastfed
Birth Defects
Maternal Depression
Domestic Violence
Long-Term Mental & Physical Outcomes
Less Education
Less Income / More Financial Aid
Unintended Pregnancy

VT Expenditures Resulting from Unintended Pregnancy

Abortion & Miscarriage

+

Prenatal Care

+

Labor & Delivery

+

Postpartum Care

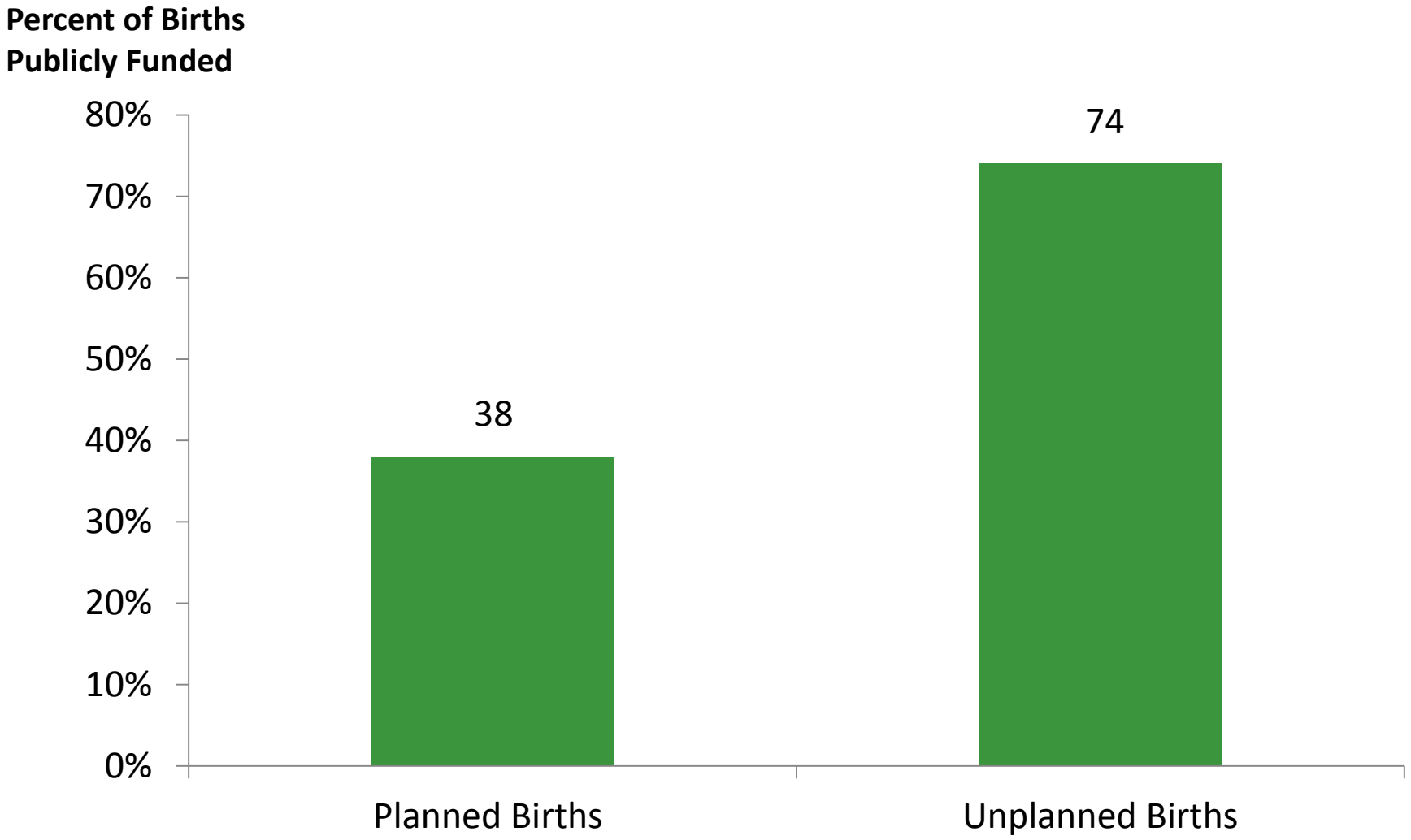
+

5 Years Care for Child

= $30 Million in 2010

Source: Sonfield A and Kost K. Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care. Guttmacher Institute, 2015.

Unplanned births in VT are nearly twice as likely to be publicly funded



Source: Sonfield A and Kost K. Guttmacher Institute 2015 .

Unintended Pregnancy Prevention

- Improves health & well-being
- Helps people finish school & find work
- Helps break cycle of poverty
- Improves population health

EPIC

EQUITY IN PREGNANCY INTENTION CAMPAIGN
PPNNE 2016-2021

Prevent unintended pregnancy to improve health and well-being and help achieve state health goals.

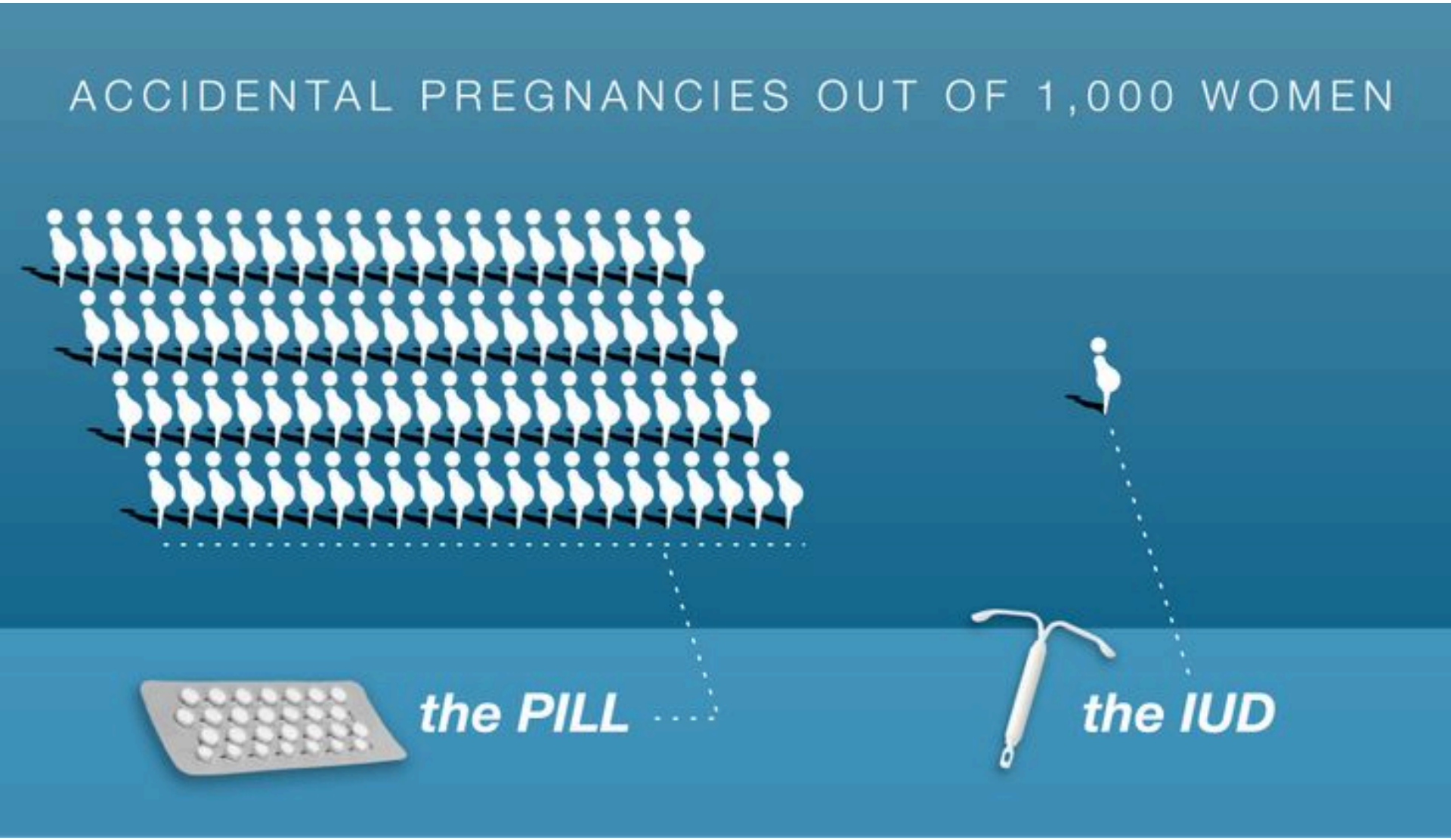
EPIC

EQUITY IN PREGNANCY INTENTION CAMPAIGN
PPNNE 2016-2021

Project Results

1. **Political support for access to birth control increased.**
2. **Awareness about LARC improved.**
3. **Use of birth control increased.**

LARCs Are Safe, Easy To Use, 99% Effective



Source: Birth Control Guide, US Food and Drug Administration, June 2014.

Misinformation

Expensive

Multiple Patient Visits

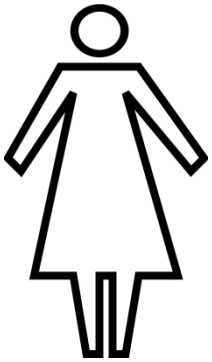
Stocking Barriers

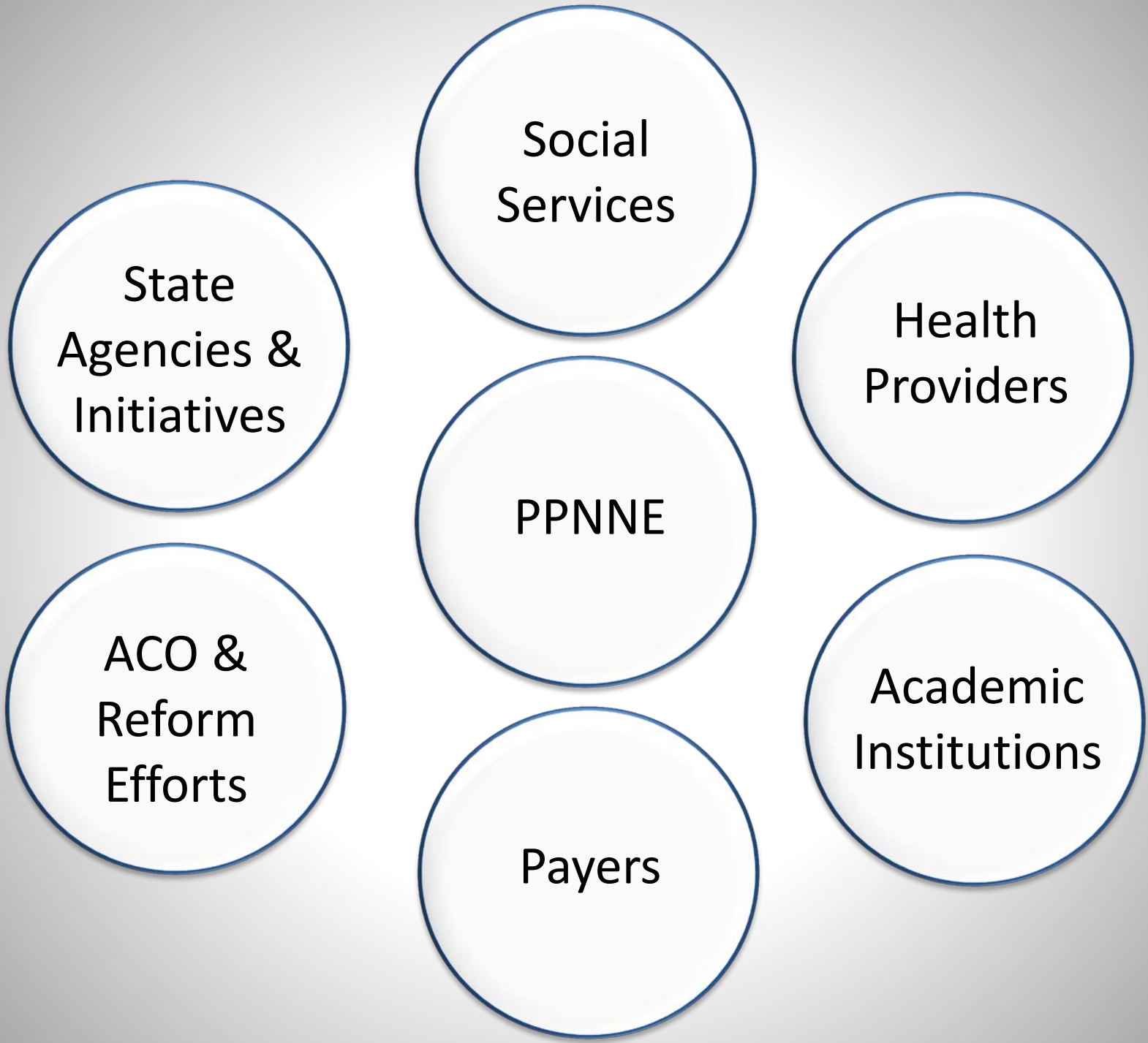
Provider Time

Low Reimbursement

Bad History

Provider Risk




Social Services
State Agencies & Initiatives
Health Providers
PPNNE
ACO & Reform Efforts
Academic Institutions
Payers


Advocacy
Mass Media
Community
Coordination
Education
Access
Expanded


Advocacy
Mass Media
Community Coordination
Education
Expanded Access

Advocacy

Participate in policymaking initiatives that protect and improve access to sexual and reproductive health care.

Access to Birth Control Law
VT 2016

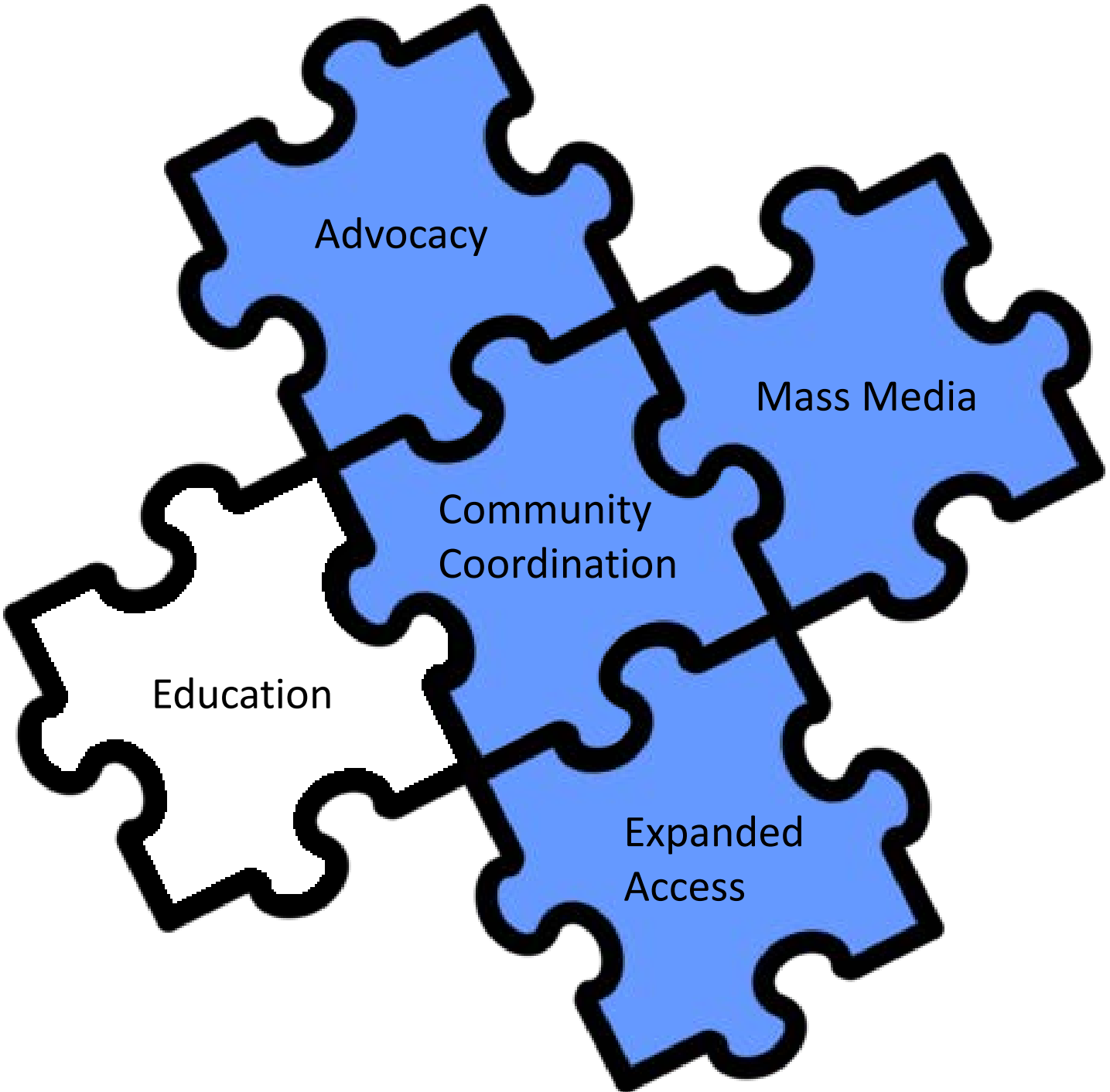
Codifies the ACA no-cost birth control benefit.

Extends benefit to include vasectomies.

Allows dispensing of one year's supply of prescription birth control.

Increases Medicaid reimbursement for LARC.

Recognizes pregnancy as a "qualifying event" on the health exchange.


Advocacy
Mass Media
Community Coordination
Education
Expanded Access

Education

Youth & Peer Education

Get Real Education

Educational Materials

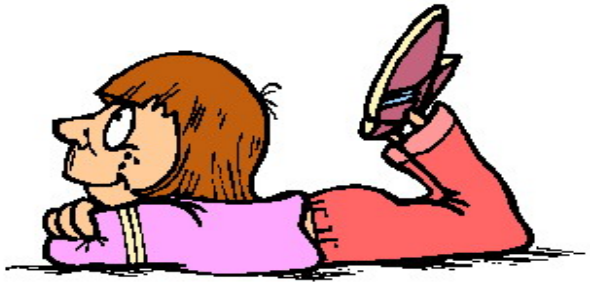

Advocacy
Mass Media
Community
Coordination
Education
Expanded
Access

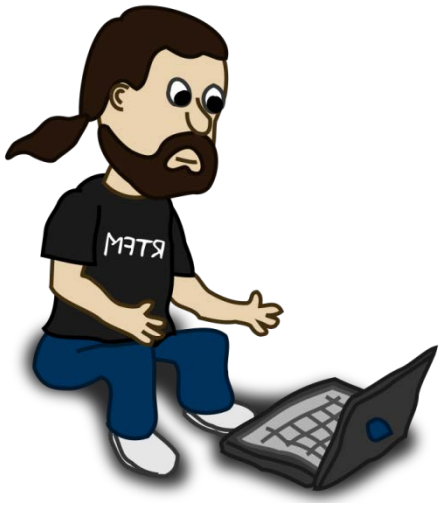
Expanded Access

1. Internal Clinical Quality Improvement
2. Telehealth
3. External Clinical Quality Improvement
    a. Contraceptive counseling trainings
    b. LARC insertion trainings (maybe)


Advocacy
Mass Media
Community
Coordination
Education
Expanded
Access

Mass Media





Public Service Announcements

Earned Media

PPNNE Advertisements


Advocacy
Mass Media
Community
Coordination
Education
Expanded
Access

Community Coordination

- State and Community Health Initiatives
- Referral Management & Relationships
  - Family Planning Referral Form
  - Medical practices, methadone clinics, DCF, NFP, correctional facilities, others.

Family Planning Referral Form

- Created by PPNNE & VDH
- Streamline FP referrals
- Provide tool for counseling
- Improve care coordination
- Build “referral loops”

FAMILY PLANNING REFERRAL FORM

DO YOU PLAN TO HAVE ANY (MORE) CHILDREN AT ANY TIME IN YOUR FUTURE? WOULD YOU LIKE TO BECOME PREGNANT IN THE NEXT YEAR?

If YES or "I'm ok either way" = Consider talking to your provider about health recommendations before you are pregnant.

If NO or "I don't know" = Consider talking to your provider about family planning and birth control options (see below).

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

	The Implant	Hormonal IUDs	Non-hormonal IUD	Sterilization, for men and women
★★★★★ Really, really well				
Works, hassle-free, for up to...	4 years	3-6 years	12 years	Forever
Less than 1 in 100 women				

	The Pill	The Patch	The Ring	The Shot
★★★★ Pretty well				
For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months
6-9 in 100 women, depending on method				

Use a condom with any other method for STI protection.

	Withdrawal	Fertility Awareness	Internal Condom	Condom
★★★ Not as well				
For each of these methods to work, you or your partner have to use it every single time you have sex.				
12-24 in 100 women, depending on method				

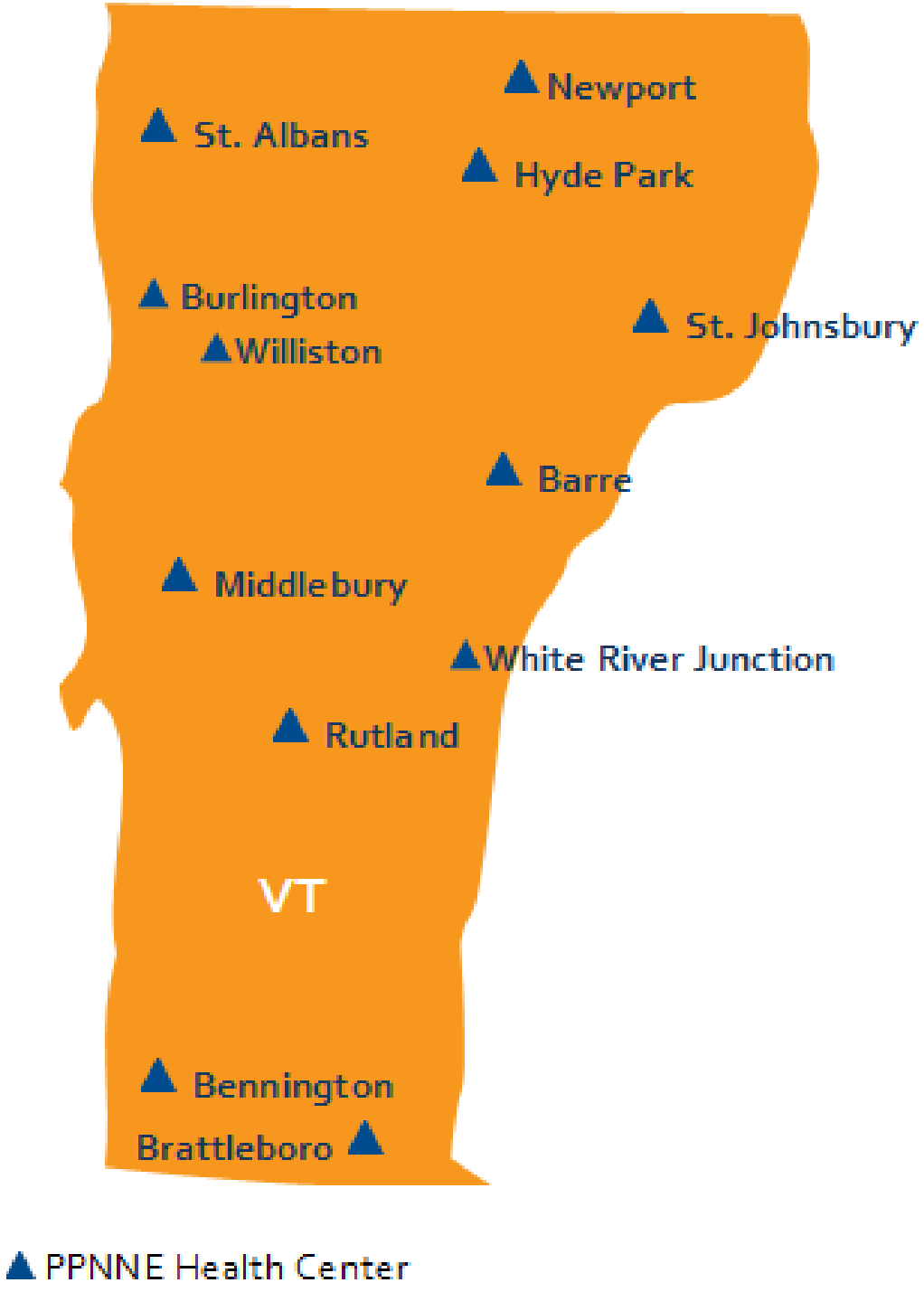
FYI, without birth control over 90 in 100 young women get pregnant in a year.

More information about family planning and birth control is available here:
American Academy of Pediatrics; American College of Obstetricians and Gynecologists; Centers for Disease Control and Prevention; National Campaign to Prevent Teen Pregnancy; Bedsider.org; Planned Parenthood Federation of America.

BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

PPNNE VT Health Center Locations



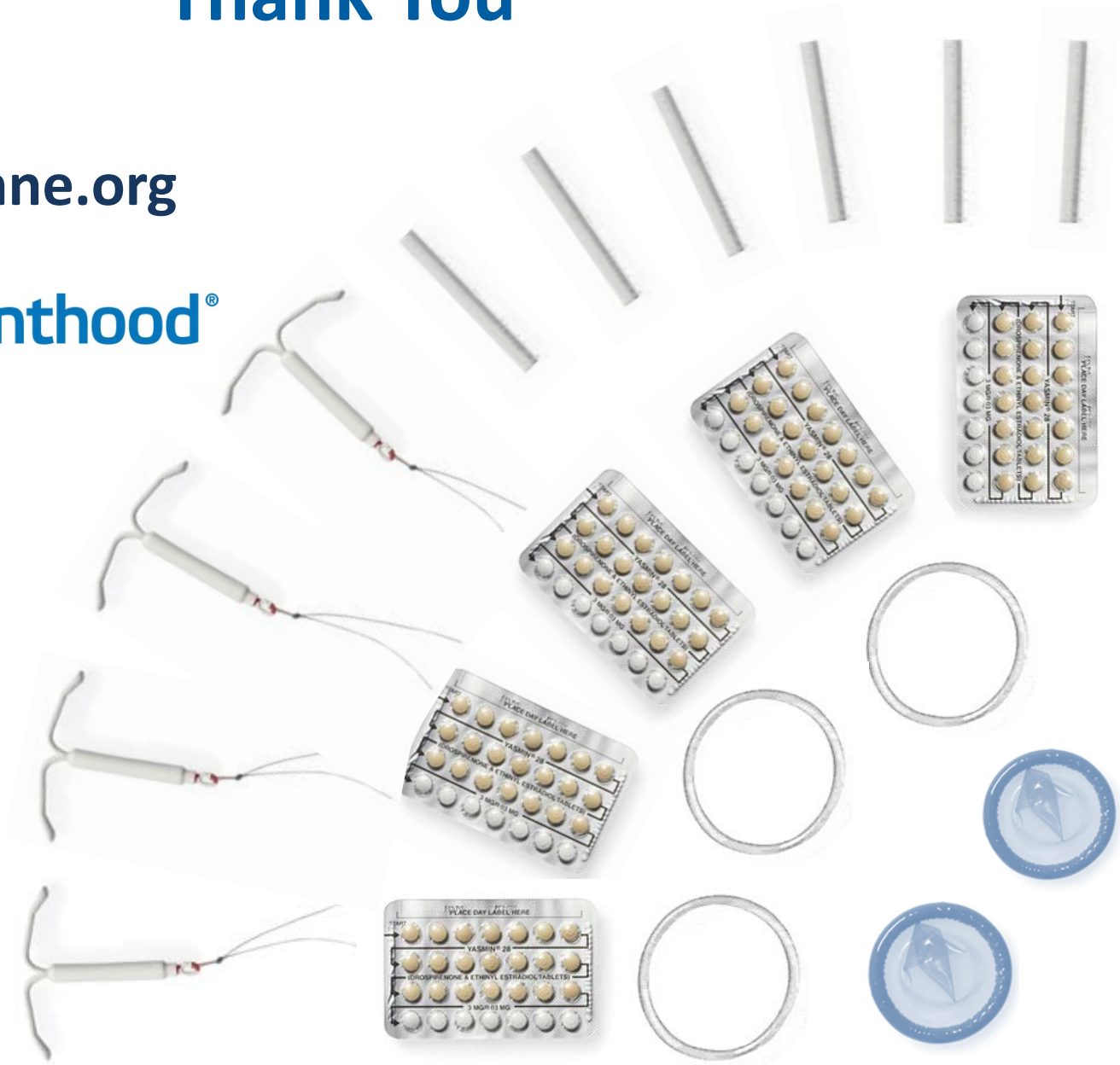
Highlights

- Preventing unintended pregnancy improves health & well-being, saves millions of dollars.
- Half of pregnancies in VT are unintended. We can do better.
- PPNNE is planning a large public health campaign to reduce unintended pregnancy: EPIC
- Expanding access to the full range of contraceptives is critical.
- We want to work with you.

Thank You

Maura Graff
maura.graff@ppnne.org

Planned Parenthood®
of Northern New England



Attachment 2a - EPIC One Page Summary

Planned Parenthood® of Northern New England

EQUITY IN PREGNANCY INTENTION CAMPAIGN

Preventing unintended pregnancy to improve health and well-being and build pathways to opportunity.

ADVOCACY	**Support progressive policymaking initiatives that protect and improve sexual and reproductive health access.** • Advocate for and implement state, regional, and national policies that improve contraceptive service delivery and access.
COMMUNITY COORDINATION & HEALTH REFORM	**Create seamless integration for sexual and reproductive health throughout the care system.** • **Care Coordination and Referral Management:** Build strong referral relationships that foster care coordination between medical practices and social service organizations, and streamline referrals for sexual and reproductive health care. • **State and Community Health & Healthcare Reform Initiatives:** Build partnerships with state and community initiatives to ensure sexual and reproductive health is a priority.
EDUCATION	**Achieve consistent comprehensive sex education to ensure all young people are empowered to be in control of their reproductive lives.** • **Youth Education**: Strengthen and expand sex education and peer programs in schools and communities. • **Get Real School Education**: Implement curriculum that empowers students to be responsible decisionmakers for healthy sexual behavior, and engages parents and teachers. • **Educational Materials**: Create informational materials for partners and stakeholders.
EXPANDED ACCESS	**Meet patients where they are with high quality sexual and reproductive health care.** • **Internal Clinical Quality Improvement:** Ensure highest-quality care at PPNNE health centers, including same-day insertions for IUDs and implants. • **Telehealth**: Provide remote reproductive health care to patients located anywhere with internet. • **External Clinical Quality Improvement**: Build capacity for sexual and reproductive health care at other medical practices and social service organizations.
MASS MEDIA	**Ensure everyone has accurate information about the full range of contraceptive methods, including IUDs and implants.** • **Public Service Announcements**: Increase awareness about birth control and influence behavior change through broad distribution of a PSA. • **Earned Media**: Participate in earned media efforts to expand the reach of the campaign's key messages. • **Marketing Campaign**: Expand PPNNE marketing through print, radio, and online advertising.

Attachment 2b - Family Planning Referral Form

FAMILY PLANNING REFERRAL FORM

DO YOU PLAN TO HAVE ANY (MORE) CHILDREN AT ANY TIME IN YOUR FUTURE?
WOULD YOU LIKE TO BECOME PREGNANT IN THE NEXT YEAR?

If YES or "I'm ok either way" = Consider talking to your provider about health recommendations before you are pregnant.

If NO or "I don't know" = Consider talking to your provider about family planning and birth control options (see below).

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well

The Implant

Hormonal IUDs

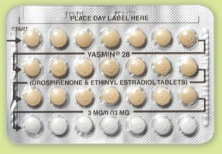
Non-hormonal IUD

Sterilization, for men and women

Works, hassle-free, for up to...	4 years	3-6 years	12 years	Forever

Less than 1 in 100 women

Pretty well



The Pill

The Patch

The Ring

The Shot

For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100 women, depending on method

Not as well

Use a condom with any other method for STI protection.

Withdrawal

Fertility Awareness

Internal Condom

Condom

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

More information about family planning and birth control is available here:
American Academy of Pediatrics; American College of Obstetricians and Gynecologists; Centers for Disease Control and Prevention; National Campaign to Prevent Teen Pregnancy; Bedsider.org; Planned Parenthood Federation of America.

BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

THE FAMILY PLANNING REFERRAL FORM IS INTENDED FOR USE BY ENTITIES COMPLIANT WITH HIPAA

REFERRING PROVIDER

COMPLETE THIS SECTION AND GIVE FORM TO PATIENT

Patient Name: _____ Date of Birth:_____Phone: _____

Referring Provider Name (Optional): _____ Phone: _____ Fax: _____

Date of Referral: _____ Purpose (check box): ☐ Birth Control ☐ Other: _____

Reproductive Health Provider Name: _____ Phone: _____ Fax: _____

REFERRING PROVIDER REQUESTS REPRODUCTIVE HEALTH PROVIDER RETURN:

- ☐ Copy of this family planning referral form
- ☐ Medical record (requiring patient authorization to release healthcare information)
- ☐ Nothing

Other Notes:

FIND A REPRODUCTIVE HEALTH PROVIDER

Family planning referrals should be made to reproductive health providers who offer the full range of birth control options, including IUDs and implants (LARCs). A list of reproductive health providers who offer IUDs and implants (LARCs) by zipcode is available online from the Association of Reproductive Health Professionals and Bedsider.org: http://larc.arhp.org/ or https://bedsider.org/clinics

REPRODUCTIVE HEALTH PROVIDER

COMPLETE THIS SECTION. RETURN TO PATIENT AND REFERRING PROVIDER IF REQUESTED.

Date of Appointment: _____

Birth control method(s) selected by patient: _____ None: _____

If IUD or implant selected: **Insertion Date:** _____ **Removal Date:** _____

Other Notes:

We appreciate the referral. Thank you!

PATIENT RELEASE OF INFORMATION

If referring provider requested return of medical record then patient must sign authorization to release healthcare information.

Attachment 3 - CFC Application of Federal Rules Reference Table

Choices for Care: Application of Federal Rules

Home-Based Settings Reference Table

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
1. *Commensurate with a persons individualized plan, needs and abilities* - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	✓	✓	N/A
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	✓	✓	N/A
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	✓	✓	N/A
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	✓	✓	N/A
5. Facilitates individual choice regarding services and supports, *and who provides them*	✓	✓	N/A
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a	✓	N/A	N/A

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Settings Requirements	Adult Family Care	Adult Day	Home-based Case Management
lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*			
7. Each individual has privacy in their sleeping or living unit	✓	N/A	N/A
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	✓✪	N/A	N/A
9. Individuals sharing units have a choice of roommates in that setting	✓	N/A	N/A
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	✓✪	N/A	N/A
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	✓✪	✓	N/A
12. Individuals are able to have visitors of their choosing *at any time*	✓✪	✓✪	N/A
13. The setting is physically accessible to the individual	✓	✓	N/A
14. Modification to HCBS Settings Requirements	✓✪	✓✪	N/A

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
1. Includes people chosen by the individual and led by person or legal rep where possible	✓	✓	✓
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	✓	✓	✓
3. Is timely, occurs at times and locations of convenience to the individual	✓✪	✓	✓✪
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	✓	✓	✓
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	✓	✓	✓
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan*, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and accessible alternative dispute resolution process*	✓✪	✓✪	✓✪
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	✓	✓	✓
8. Includes a method for the individual to request updates to the plan as needed	✓	✓	✓
9. Records the alternative home- and community-based settings that were considered by the individual	✓	N/A	✓

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
10. Reflect that the setting in which the individual resides is chosen by the individual.	✓✪	✓	✓✪
11. Reflect the individual's strengths and preferences	✓	✓	✓
12. Reflect needs identified through functional assessments	✓	✓	✓
13. Include individually identified goals and desired outcomes	✓	✓	✓
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	✓	✓	✓
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	✓	✓	✓
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)	✓	✓	✓
17. Identify the individual and/or entity responsible for monitoring the plan	✓	✓	✓
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	✓	✓	✓
19. Be distributed to the individual and other people involved in the plan	✓	✓	✓
20. Include those services, the purpose or control of which the individual elects to self-direct	✓	✓	✓
21. Prevent the provision of unnecessary or inappropriate services and supports	✓	✓	✓
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or	✓	✓	✓

✓ = Rule applies, NA = Rule Does Not Apply, ✪= VT Needs to Strengthen Requirements

CMS Person-Centered Planning Requirements	Adult Family Care	Adult Day	Home-Based Case Management
at the request of the individual			
23. Modifications to the Person-Centered Plan	✓✪	✓✪	✓✪

Attachment 3a - CFC Work Plan

Department of Disabilities, Aging and Independent Living (DAIL)
Choices for Care HCBS Work Plan

This document represents the DAIL's improvement and action steps to strengthen Vermont's Choices for Care home and community-based services system. It was developed as part of the State's Comprehensive Quality Strategy (CQS). The CQS calls for the systemic assessment of the alignment of Choices for Care Long Term Services and Supports with recent federal Home and Community Based Services standards related to person-centered planning and home and community based settings. The CQS also calls for an improvement and quality monitoring plan to address any areas of weakness based on the findings of the systematic assessment. Choices for Care planning included the following activities:

- Presentation of the State's Proposed Comprehensive Quality Strategy and its relationship to the HCBS regulations to the DAIL Advisory Board (August 13, 2015);
- A review of policies and rules governing Choices for Care operations (*Choices for Care Managed Long-Term Services and Supports Systemic-Assessment of Person-Centered Planning and Home- and Community-Based Settings Policies* (*Pacific Health Policy Group, October 27, 2015; revised December 2015*);
- Distribution of and a solicitation for input on a draft work plan and alignment findings (November 9, 2015);
- Positing of the draft work plan and alignment findings to the DAIL Adult Services Division and DVHA websites (November- December 2015);
- Presentation of the draft work plan and alignment findings at the DAIL Advisory Board (December 10, 2015); and
- The State's review of stakeholder feedback and incorporation of changes in final work plan and findings report (December 18, 2015).

Based on feedback received the State updated its findings and draft work plan as it relates to the Enhanced Residential Care Settings. Specifically, the State proposed additional action steps in the areas of case management and conflict of interest requirements in this Private Non-Medical Institution (PNMI) setting. Additionally, the State will initiate the provider self-assessment process earlier in the work plan timeline. Outlined on the following pages are the improvements/action steps that have been prioritized for Choices for Care settings.

The primary lead for Choices for Care proposed improvements/actions steps rests with the Department of Disabilities, Aging and Independent Living (DAIL). All improvements/actions steps will be managed in collaboration with program stakeholders, the Vermont Agency of Human Services (AHS) and the Department of VT Health Access (DVHA). The work plan will commence in January 2016 and is anticipated to be complete by December 2016.

Choices for Care Step 1 - Home-Based Settings: Adult Family Care (AFC) and Adult Day (AD) Settings

Regulation: Settings Requirements	Findings	Proposed Improvements/Action Steps
#8. AFC Setting: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	AFC service plans and live-in agreements would benefit from more specific guidance regarding participant preferences and needs. Standards for AD services are silent on visitors #8, #10 and #11 are not applicable to AD since it is not a residential option.	a. DAIL to provide a self-assessment tool to Adult Family Care and Adult Day providers. b. DAIL to update the Choices for Care Program Manual, ***Section IV.11 Adult Family Care*****,** to reflect regulatory requirements. http://ddas.vt.gov/ddas-policies/policies-cfc/policies-cfc-highest/section-iv-11-adult-family-care c. DAIL to update CFC ***Agreement for Live-in Care.*** http://ddas.vt.gov/ddas-programs/cfc-live-in-requirements. d. DAIL to update AFC ***Participant Rights*** to reflect regulatory requirements. e. DAIL to update the ***Standards for Adult Day Services in Vermont*** to address regulatory requirements. http://ddas.vt.gov/ddas-programs/ddas-policies/policies-adult-day/policies-adult-day-documents/standards-for-adult-day-services-vt. f. DAIL to solicit stakeholder feedback on updated documents. g. DAIL to incorporate feedback into documents. h. DAIL to publish revised documents and distribute to
#10. AFC Setting: Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement		
#11. AFC Setting: Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.		
#12. AFC & AD Settings**:** Individuals are able to have visitors of their choosing *at any time*		
#14. AFC & AD Settings: Modification to HCBS Settings Requirements	AFC and AD provider documentation requirements could be stronger regarding modifications to the settings requirements.	

Regulation: Settings Requirements	Findings	Proposed Improvements/Action Steps
		stakeholders. i. DAIL to incorporate related elements of consumer experience of care into the DAIL annual consumer survey j. DAIL to provide training and technical assistance to providers and stakeholders as needed. k. AHS, DAIL and DVHA to evaluate results of the provider self-assessment tools. l. DAIL to coordinate ASD quality activities with AHS and DVHA quality assurances under the Global Commitment Comprehensive Quality Plan (CQP).

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
#3. HB & AFC Settings: Is timely, occurs at times and locations of convenience to the individual ***#10. HB & AFC Settings:*** Reflect that the setting in which the individual resides is chosen by the individual. ***#14. HB & AFC Settings:*** (same as settings requirements) Modifications to Person-Centered Planning requirements.	Guidance discusses participant direction but does not specify time and location arrangements. Documentation could be strengthened.	a. DAIL to provide a self-assessment tool to Case Management and Adult Family Care providers. b. DAIL, AHS and DVHA to evaluate results of the provider self-assessment tools. c. DAIL to update the Choices for Care Program Manual, ***Section IV.1 Case Management Services***, to reflect regulatory requirements. http://ddas.vt.gov/ddas-policies/policies-cfc/policies-cfc-highest/section-iv-1-case-management-1. d. DAIL to update the Choices for Care Program Manual, ***Section IV.11 Adult Family Care*****,** to reflect regulatory requirements. http://ddas.vt.gov/ddas-policies/policies-cfc/policies-cfc-highest/section-iv-11-

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
		adult-family-care e. DAIL to update ***Case Management Standards and Certification Procedures*** for more specificity. http://ddas.vt.gov/ddas-programs/programs-oaa/revised-case-management-standards. f. DAIL to solicit stakeholder feedback on updated documents. g. DAIL to incorporate feedback into documents. h. DAIL to publish revised documents and distribute to stakeholders. m. DAIL to provide training and technical assistance to providers and stakeholders as needed. n. DAIL to incorporate related elements of consumer experience of care into the DAIL annual consumer survey. i. Coordinate ASD quality activities with DVHA and AHS quality assurances under the Global Commitment Comprehensive Quality Plan (CQP).

Choices for Care Step 2 - Non-home-based: Enhanced Residential Care (ERC) Setting (PNMI)

Regulation: Settings Requirements	Findings	Proposed Improvements/Action Steps
#1 ERC Setting: Commensurate with a persons individualized plan, needs and abilities - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS	Due to nature of PNMI (Private Non-Medicaid Institution) and Licensing Standards some settings may be located on the grounds of private hospitals or nursing facilities. Residential Care Home Licensing Regulations are silent regarding lockable door requirements Residential Care Home Licensing regulations are silent regarding how roommates are assigned in semi-private situations Residential Care Home Licensing regulations are silent on the topic of furnishing and décor. Residential Care Homes offer meal plans and are required make options available as requested by participants. Regulations are silent on 24/7 access Residential Care Home Licensing regulations outline minimum standards (e.g., 8 am to 8 pm) not maximum	a. DAIL to provide a self-assessment tool to ERC providers. b. DAIL, AHS and DVHA to evaluate results of the provider self-assessment tools. c. DAIL to incorporate relevant HCBS features into ***Residential Care Home*** regulations for Level III and Assisted Living Residences. http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/rch-licensing-regulations. d. DAIL to incorporate relevant HCBS features into Choices for Care Program Manual, ***Section IV.8 Enhanced Residential Care***. http://ddas.vt.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-manual e. DAIL Solicit stakeholder feedback on revised documents. f. DAIL to publish revised final documents. g. Training and technical assistance providers as needed. h. DAIL to incorporate revised standards into regulatory and quality review and activities through the Division of Licensing and Protection and Adult Services Division. i. DAIL to coordinate quality and licensing review activities with DVHA and AHS quality assurances
#8 ERC Setting: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors		
#9. ERC Setting: Individuals sharing units have a choice of roommates in that setting		
#10. ERC Setting: Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement		
#11. ERC Setting: Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time		
#12. ERC Setting: Individuals are able to have visitors of their choosing *at any time*		

Regulation: Settings Requirements	Findings	Proposed Improvements/Action Steps
#14. ERC Setting: Modification to HCBS Settings Requirements	Documentation requirements could be stronger.	under the Global Commitment Comprehensive Quality Plan (CQP).

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
#3. ERC Setting: Is timely, occurs at times and locations of convenience to the individual.	Guidance discusses participant direction but does not specify time and location arrangements.	***See above action steps.***
#5. ERC Setting: Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	ERC specific conflict of interest standards could be strengthened due to the nature of the all-inclusive package.	
#6. ERC Setting: Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process	Due to nature of the all-inclusive payment, persons who choose these living options are also choosing an all-inclusive service package that includes case management.	

Regulation: Person-Centered Planning	Findings	Proposed Improvements/Action Steps
#9. ERC Setting: Records the alternative home- and community-based settings that were considered by the individual	Documentation could be strengthened (#9 and 10).	
#10. ERC Setting: Reflect that the setting in which the individual resides is chosen by the individual.		

Attachment 3b - CFC HCBS Final Alignment Report

State of Vermont

Comprehensive Quality Strategy Systemic Assessment

Section III State Standards:

Home and Community Based Services

Choices for Care Managed Long-Term Services and Supports

December 2015

Table of Contents

Background

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS's intent to ensure that individuals receiving services and supports under 1915(c) HCBS waivers, 1915(k) (Community First Choice), and 1915(i) State Plan HCBS Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting.

The State of Vermont has been particularly progressive in pursuing a home- and community-based continuum of care that offers meaningful community integration, choice, and self-direction, and strives to promote health, wellness, and improved quality of life. In doing so over the years, the State has used many authorities available under the Medicaid State Plan's rehabilitation option, as well as former 1915(c) waivers and Medicaid Section 1115 Demonstration projects. Additionally, guidance and assurances for home- and community-based care in Vermont are codified in statute or placed in rule. As a result, the term "home and community based" is used in Vermont to represent a broad array of services and supports that may not be typical of 1915(c) populations and CMS rules in other states, but that have been authorized under its Section 1115 Demonstration.

As part of Vermont's Global Commitment to Health (GC) Section 1115 Demonstration amendment, effective January 30, 2015, CMS has asked Vermont to provide assurances that the State's Managed Long-Term Services and Supports (MLTSS) in the Choices for Care Program are in compliance with certain aspects of the HCBS rule, specifically those related to the setting requirement and person-centered approaches for service planning. Two specific Special Terms and Conditions (STC's) from the GC Section 1115 Demonstration are summarized below:

- Person-centered planning (i.e., the process, the service plan, and the review of the service plan) will be in compliance with the characteristics set out in 42 CFR 441.301 (c)(1)-(3) (STC #29)

- Compliance with the characteristics of home- and community-based settings in accordance with 42 CFR 441.301 (c)(4) for Choices for Care Services (*i.e., those not found in the Vermont State Plan*) (STC #32).

Because of Vermont's public managed care delivery system, the State is integrating person-centered planning and integrated community setting assurances into its Comprehensive Quality Strategy for all Specialized Programs. Regardless of the setting type that beneficiaries choose, Vermont's values are in alignment with the Federal HCBS values. As such, at its discretion and over time, the State's Comprehensive Quality strategy will review the rules and guidance supporting all Special Health Need Populations served under the Demonstration and services provided in community settings authorized under the State Plan and the Global Commitment Demonstration. This report focuses on the Choices for Care Program.

HCBS Institutional Level of Care for Eligibility and Enrollment

Persons may become eligible for participation in the Choices for Care (CFC) Long-Term Care program by meeting Medicaid Long-Term Care eligibility rules, 1915(c) institutional eligibility rules, GC Demonstration population rules, and by also meeting clinical criteria for High, Highest, or Moderate Needs services. Persons designated as High or Highest Needs must meet nursing facility level of care, and persons with Moderate Needs are at risk for nursing home level of care. Persons with Moderate Needs are eligible for a limited benefit package to assist them in remaining in their home. Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules and are in the High or Highest Needs Group (i.e., meeting a nursing facility level of care).

Program Settings and Services

In the CFC program consumers have equal access to an array of traditional State Plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing, home–based, and other rehabilitative service options. The final service package is based on consumer choice, individualized planning, medical necessity (including level-of-care determinations), and medical appropriateness; thus, individual plans may include institutional, home-based, and other rehabilitative-based services as part of their person-centered planning process.

The majority of Choices for Care services are provided to participants in their homes. However, persons may also choose to reside in one of the following out-of-home setting types:

> *Adult Family Care (AFC)* – A 24-hour, home-based, shared living arrangement providing care for no more than two persons unrelated to the provider. Adult Family Care homes must meet DAIL safety and accessibility standards prior to participant placement, with inspections every three years. Each AFC home maintains a contract with a Host Agency responsible for quality oversight and case management services on behalf of the participant. An Adult Family Care Coordinator from the host agency assists the home provider and participants in creating a person-centered care plan and live-in agreement. Home providers do not serve as case managers or guardians for persons in their care.
>
> *Enhanced Residential Care (ERC)* – Residential Care Homes in Vermont are licensed to provide room, board, and personal care to three or more residents unrelated to the provider. CFC ERC services involve a daily package of services provided to individuals residing in an approved, Vermont Licensed Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). All CFC ERC providers must also be enrolled as Medicaid Assistive Community Care Service (ACCS) providers and receive a Medicaid payment for Assistive Community Care Services (i.e., private non-medical institution), as well as an enhanced residential care payment for services to CFC participants. Prior to participation in the CFC ERC program, providers must request a variance of licensing standards that restrict residential admissions to persons who do not meet Nursing Facility level of care. A summary of the State Plan and Choices for Care authorities and payment types are provided on Table 1 on the following page.

Nursing Facility (NF) – 24-hour nursing care and supervision provided by a VT Licensed Nursing Facility.

Table 1 State Plan and Choices for Care Authorities Related to ERC Providers

Beneficiary Type	Provider ACCS Enrollment	Payment Type	State Regulations
General Public	Not required	Self	RCH and ALR Licensing Regulations
Medicaid Recipient	Optional	Self or ACCS	RCH and ALR Licensing Regulations including ACCS enrollment
Choices for Care Recipient	Required	ACCS plus CFC Enhanced Residential Care	All of the above plus Choices for Care Regulations and Universal and Other Provider Requirements

In addition to these residential arrangements, CFC participants who are residing in their own homes or in an Adult Family Care setting may also receive Day Health Rehabilitation from a State-Certified Adult Day Service provider. Day Health Rehabilitation is a State Plan service and is defined below.

Day Health Rehabilitation: Services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services.

Table 2 below shows the service array available to Choices for Care participants and their coverage authority.

Table 2: Choices for Care Program Benefits

42 CFR 440.180 HCBS Service	**Choices for Care Benefit**	**Coverage Authorization (Medicaid State Plan or Global Commitment)**
Case Management	Case Management	GC
Home Maker	Home Maker - Moderate Needs Group only	GC
Personal Care	Personal Care	GC
Adult Day Rehabilitation	Adult Day	State Plan -Day Health Rehabilitation
Habilitation	Enhanced Residential Care - Assisted Living Residences	State Plan - Private Non-Medical Institution (Assistive Community Care Services)
	Enhanced Residential Care – Level III Residential Care Home	State Plan - Private Non-Medical Institution (Assistive Community Care Services)
	Adult Family Care	GC
	Nursing Facility Care	State Plan- Nursing Facility
Respite	Respite Care (in home or foster home)	GC
Other Cost-Effective Alternatives	Companion Care	GC
	Assistive Devices and Home Modifications	GC
	Personal Emergency Response System	GC

Due to the nature of Vermont's Medicaid State Plan, the GC STCs, and Medicaid Managed Care rules, expenditures for the full continuum of service (home based, shared living, enhanced residential, and nursing facility care), commensurate with participant needs and choice, are allowable under Vermont's Section 1115 Demonstration.

Policy Overview

The Choices for Care program has a variety of written materials associated with its operations. These materials range from APA-promulgated rule and licensing standards to operations manuals, provider certification standards, audit tools, and training guides. One document, the DAIL Case Management Action Plan Guide is currently not in use, it was reviewed to assess its applicability and need for revision. The following documents were reviewed as part of this project:

- Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations (February 2009)
- Choices for Care Long-Term Care Medicaid Program Manual (August 2013 Revised)
- DAIL Revised Case Management Standards Certification Procedures (June 2009)
- DAIL Case Management Action Plan Guide (Inactive and under consideration for revision)
- Residential Care Home Licensing Regulations (October 3, 2000)
- Assisted Living Licensing Regulations (March 15, 2004)
- Adult Family Care Training Materials (September 1, 2013)
- Adult Family Care Sample Live-In Agreement Template
- Adult Family Care Participant Rights
- Standards for Adult Day Services in Vermont (Effective March 1, 2012).

Appendix A and B provide a more detailed crosswalk of Vermont policy documents to the federal HCBS rules. Elements responsive to federal rules were scored using the following categories:

Alignment:	State policy documents show alignment with federal rules.
Partial:	State policy documents show general alignment with federal rules, but lack specificity.
Silent:	State policy documents do not mention specific terms contemplated in federal rule.
Non-Comply:	State policy documents are in conflict with the terms contemplated in federal rule.

Brief summaries of Adult Family Care and Enhanced Residential Care policies are provided below.

Adult Family Care: Choices for Care materials for Adult Family Care state that the goal is to provide individualized supports in an environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity. The home provider is expected to ensure that the environment promotes a positive domestic experience and to assist the person in realizing their maximum potential for independence.

The Adult Family Care Participants' rights agreements include stipulations that the live-in agreement must address such concerns as, but not limited to: visitation, diet/food, and access to activities in the community. All parts of the agreement must be based on the person's desires and the person-

centered plan, and be approved by the participant or his or her legal representative in a written live-in agreement.

DAIL provides a sample agreement; the household arrangement section focuses on whether each identified physical space (bedroom, bathroom, kitchen, living room, and other space) is shared or private. The template includes negotiated risk, conditions regarding any termination of the agreement, room and board, and acknowledgments of Participants' Rights. Other considerations are noted in a free-form text box at the end, identified as "Other." Private or semi-private accommodations are agreed to by each specific arrangement and noted in the live-in agreement. No more than two persons needing care may reside in a single Adult Family Care setting. AFC home providers do not serve as case managers or control participants' finances or health decisions.

Enhanced Residential Care: CFC ERC services may be provided in an Assisted Living Residence or a Residential Care Home-Level III. These Choices for Care settings are governed by three sets of regulations (see Table 1 above), and all serve the general public as well as Medicaid and Choices for Care enrolled participants. Residential Care Home and Assisted Living Licensing Regulations address choices, physical accessibility, individual rights to privacy, and control. Licensing regulations also indicate that a home must respect the individuality of its residents and promote maximum independence. Written agreements are required for room and board, negotiated risk contracts, and the agreed-upon service options. The CFC Universal Provider Qualifications and Standards listed in the CFC Long-Term Care Medicaid Manual require, among other things, that all CFC providers encourage and assist participants to direct as much of their care as possible and that they maintain safeguards and procedures to address potential conflicts of interest.

Assisted Living Residences provide specificity related to lockable doors, private units, and lease agreements. Residential Care Homes, Level III Regulations provide overarching values related to privacy, dignity, and independence. These regulations allow for providers to structure and define visiting hours, meal plans, and daily social/recreational routines within the parameters outlined in regulation. Residential Care Home regulations do not specify whether a resident's room must be lockable.

In addition to examples of autonomy and privacy found in the federal rule, Vermont Residential Licensing Rules provide that residents also have a right to:

- communicate privately;
- receive and send unopened mail;
- have access to a phone;
- refuse care (to the extent allowed by law);
- refuse visitors; and
- leave the residence at any time and be away for more than 24 hours.

Persons in ERC settings are receiving an all-inclusive package of services and do not receive case management services from an outside agency. Persons who choose to receive services in an ERC setting are also by default agreeing to potential limitations in: visiting hours, transportation,

independent access to food or meal preparation, and the timing and type of social recreational options. Participant choice of facility may also include Residential Care settings that are located on community hospital or private nursing facility grounds.

Summary and Options for Next Steps

Choices for Care statutory and regulatory framework appears to substantially align with the values in the federal framework and requires many of the same safeguards. All residential arrangements in the Choices for Care program, including Adult Family Care, must be commensurate with assessment findings, individualized long-term service and support goals, consumer abilities and desires, and meaningful choice per Choices for Care regulations. However, specific DAIL guidelines, checklists, model agreements, and quality oversight tools to ensure that providers are using best practices could provide more detailed guidance. For example, Choices for Care regulations and DAIL Case Management Standards require person-centered planning; however, guidelines and training tools do not describe what that planning entails or offer specific steps or checklists that provide examples of person-centered planning practices or practices that are not acceptable.

DAIL licensing and certification activities include a review to determine whether various standards are being met, but may not include quality or provider's performance data related to how well the standards are implemented. Along these lines, the Adult Family Care standards indicate that live-in agreements and care plans should address all aspects of the participant/provider agreement with respect to visitors, privacy, community access, and diet and nutrition; however, DAIL's sample template largely deals with physical space, risk, lease, and room and board payments. Similarly, the Adult Family Care Service Authorization form provides the service type, duration, and rates, but does not provide a summary overview of care plan goals, objectives, or agreed-upon modifications.

A preliminary list of options for enhancing quality oversight and providing more specific and direct guidance related to State and federal values and rules is provided in Table 3 below. This list should not be considered exhaustive; more extensive stakeholder engagement may yield additional opportunities for ongoing quality assessment and improvement.

Table 3 Preliminary List of Options for Quality Assessment and Improvement

Preliminary List of Options for Quality Assessment and Improvement	
Potential Next Steps	**Considerations**
Revise Residential Licensing Regulations to include more detailed standards related to specific setting characteristics	• Regulations define State expectations for all settings regardless of type • Licensing reapplications are required annually • Revisions may also impact providers not involved with the Choices for Care or Medicaid program • Regulation changes do not guarantee quality monitoring and improvement processes • Regulatory revision process may be time

Preliminary List of Options for Quality Assessment and Improvement	
Potential Next Steps	**Considerations**
	consuming and delay implementation of desired provider change
Require providers receiving ERC payments under CFC to meet additional detailed standards, such as the submission of quality strategies and data with each ERC variance request and/or a HCBS self-assessment	• Standards could clearly define DAIL expectations for all settings regardless of type • Standards could engage ERC providers in quality oversight and improvement planning • Small providers may not have quality planning resources and may no longer participate in the ERC program
Conduct periodic consumer and stakeholder assessments of provider adherence to standards	• Consumer self-report could allow for more direct and targeted quality improvement • Stakeholders could include family members, legal guardian, and ombudsmen reports
Enhance DAIL Case Management Certification Standards and audits with a review of specific details regarding person-centered planning and HCBS settings characteristics	• Standards could focus provider attention on the importance of case management in monitoring care planning and community settings • Existing audit tools could be enhanced to include key information related to the quality-of-care planning processes and the case manager's oversight of alternative settings • Audits may require more resources if content is expanded
Enhance CFC annual service authorizations (e.g., hours and rates) with additional DAIL review of information regarding care planning process (e.g., level and type of participants, areas addressed, and goals)	• Current AHS plans to update its IT structure provide an opportunity for DAIL to define information needed to augment current provider performance and quality monitoring
Update or create tools and guidance that support desired characteristics such as: • Person-centered planning checklist for case management and ERC providers • Sample AFC live-in agreements • Sample Residential agreements • Participant handbooks • Case Management Plan Action	• Updating sample templates could more clearly define State expectations for all settings regardless of type • Checklist would provide opportunity for performance monitoring and more direct quality improvement planning • Revising current trainings materials would provide ongoing access to clear examples of State expectations
Ensure that the person-centered planning elements delineated in the DAIL Case Management Standards are applicable to all agencies (ERC and Adult Family Care Host Agencies) that support assessment and care planning services.	• Creating a subset of universal case management standards for all settings could more clearly define State expectations regardless of type

Appendix A: HCBS Settings Requirements and Vermont Regulation and Policy Crosswalk

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
1. Commensurate with a persons individualized plan, needs and abilities - The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS	**CFC Regulations** Sec. 1 A; Sec. II. A; Sec. VII. B 5, B 6, C. **Case Management Standards & Certification Procedures** Section IV. A. **CFC Program Manual** Sec. IV. 11 D. 8, E. **Adult Family Care Training Materials** Goal and General Policies; Sec. 1. b-c; 2 b. **Adult Family Care Participant Rights** **Standards for Adult Day Services** Sec. I. A, B Sec. XIV. F	• CFC regulations assume community living in the purpose statement to equalize the entitlement between home and community services and nursing facility but do not specifically discuss each type of setting. Regulations provide that persons receive services in settings of their choice, commensurate with their abilities and person-centered plans. • Case management standards support planning that promotes the least restrictive, most appropriate setting in accordance with needs and preferences. • ERC settings accept Medicaid and non-Medicaid admissions and are not disability specific. • ERC settings must also be enrolled ACCS providers and as such receive State Plan payments as Private Non-Medical Institutions (PNMI). While Vermont programs are often small and based in community neighborhood settings, PNMI facilities may also be associated with or on the grounds of, community hospitals and private nursing facilities. • Employment and access to competitive work is not a goal area within Choices for Care. • Participants' Rights include individuality and community participation. • Adult Day Center Standards require that facilities be located to provide the greatest accessibility to the communities from which participants are drawn, in proximity to other services, and convenient to private and public transportation. • Adult Day services are designed to assist adults to remain as active in their communities as possible and ensure optimal functioning.	Alignment	Partial Due to nature of PNMI and Licensing Standards some settings may be located on the grounds of private hospitals or nursing facilities.	Alignment
2. The setting is selected by the individual from among setting options including non-disability specific settings and an	**CFC Regulations** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); A 2 (c) and (g); C. **CFC Program Manual**	• CFC regulations provide that persons receive information on all options available within the Choices for Care Program. • Case management certifications and service planning standards provide that the person receive services in the least restrictive and most appropriate setting in accordance with needs and preferences.	Alignment	Alignment	Alignment

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board	Sec. III. C 7. Section IV. 11, D 8. **Case Management Standards & Certification Procedures** Section IV. C. **Adult Family Care Service Plan** (Consent Statement regarding options)	• Staff is required to discuss all available long-term care options as part of the application process, including choice of settings; however, it is unclear where the setting choice is documented for ERC. • Assistive Community Care Services (e.g., Enhanced Residential Care Level III and Assisted Living Residences) are facilities open to the general public looking for enhanced support as they age. They are non-disability specific options available to Choices for Care Program participants. Private units are available depending on the specific facility and its unique arrangements. • All settings require separate room and board agreements.			
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	**CFC Regulations** Sec. XIII. B 1-7 **Adult Family Care Participants' Rights Agreement** **Residential Care Homes Licensing Regulations** Sec. 5.14 Sec. 6 **Assisted Living Licensing Regulations** Sec. I. 1.1, Sec. VI. 6.7 **Standards for Adult Day Services** Sec. I. A Sec. VIII. C Sec X. A, B, G, J, K,	• CFC Regulations require processes to prevent and address abuse, neglect, and exploitation including, but not limited to, long-term care ombudsmen services. • Certification standards and service planning guidelines include participants' rights agreements that call for the safeguarding of rights of privacy, dignity, and freedom of coercion, restraint , and reprisal.	Alignment	Alignment	Alignment

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact	**CFC Regulations** Sec. VII. B 5 **CFC Program Manual** Sec. III. C 7. Sec. IV. 11 D 8, E **Case Management Standards & Certification Procedures** Sec. II. Sec. IV. B 1-3 **Residential Care Home Licensing Regulations** Sec. 1.1; 5.5(b); 5.10 (e) (2) Sec. VI. **Assisted Living Licensing Regulations** Sec I. 1.1 Sec VI. 6.7; 6.9(a); 8.1 **Adult Family Care Training Materials** Goal and General Policies At a Glance 1.b-c; 2.b **Adult Family Care Participant Rights Standards for Adult Day Services** Sec. I. A, B	• Adult Family Care providers are expected to ensure that the environment promotes a positive domestic experience and to assist the person in realizing maximum potential for independence. • Adult Family Care is expected to include community access, leisure time activity, and participation in community functions. • Adult Family Care and Residential Care Home Participants' Rights include life choices such as the right to visitors and the right to refuse visitors, as well the right to a phone and mail, and the right to leave the residence and be gone for more than 24 hours at any given time. • The Adult Family Care participants' rights agreements include stipulations that the live-in agreement must address such concerns as, but not limited to: visitation, diet/food, access to activities in the community, and visitors. • Case managers are required to assist persons to remain as independent as possible in accordance with their wishes. • Case management standards include respecting participants' rights, strengths, and values; encouraging the person to create, direct, and participate in the plan and make their own decision about who to involve; creating acceptable risk agreements; and developing negotiated risk agreements when necessary. • Residential Care Home licensing regulations require settings to promote personal independence in a home-like environment; respect dignity, accomplishments, and abilities; and encourage participation in own ADL's, care planning, and self-administration of medication for persons who are capable. • Assisted Living Licensing Regulations provide for the promotion of individuality, privacy, dignity, self-direction, and active participation in decision making; care plans are required to support dignity, privacy, choice, individuality, and independence.	Alignment	Alignment	Alignment

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
	Sec. X. A, B, F Sec. XII. D	• Assisted Living Licensing regulations require a daily program of activity, including periodic access to community resources. • Participants have the right to refuse any services or activities offered. • Adult Day Services are designed to assist adults to remain as active in their communities as possible and ensure optimal functioning. Standards include optimizing self-direction, autonomy, and choice.			
5. Facilitates individual choice regarding services and supports, *and who provides them*	**Choices for Care Regulation** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C **Case Management Standards & Certification Procedures** Sec. IV. A, B, C **CFC Program Manual** Sec. III. C 7 Sec. IV. 11, D 8, E **Adult Family Care Training Materials** Goal and General Policies; Sec. 1. b-c, 2. b **Adult Family Care Participant Rights** **Adult Family Care Service Plan** (Consent Statement) **Standards for Adult Day**	• All Participants choose where to receive their long-term services and supports. • Participants choosing Adult Family Care receive case management from a host agency. The host agency is responsible for contracting with the home provider and facilitating an acceptable match of shared living setting and a person-centered plan between the home provider and the recipient. The host agency is responsible for oversight of the care plan and following up on any client concerns with the home, plan, or other services. • Participants who choose ERC in a Residential Care Home or Assisted Living Residence receive an all-inclusive package of services that includes case management. • Participants residing in ERC settings may arrange and pay for additional services and supports. • Participants may self-manage their own care through the Flexible Choices program.	Alignment	Alignment	Alignment

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
	Services Sec. I. A, B Sec. X. A, B Sec. XI. D4				
6. (a) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. (b) For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in	**CFC Program Manual** Sec. IV. 11 D.11 **Residential Care Home Licensing Regulations** Sec. 4.3 (b), (d), (e) Sec. 5.2 (a-d), 5.3 (a), (e-h) Sec. 6.14 **Assisted Living Licensing Regulations** Sec. 3.3, 3.4 Sec. 6.5, 6.12, 6.14 Sec. 7.1 Sec. 8.2 Sec. 9 **Adult Family Care Participant Rights** Sec. 2, 13, 14	• Adult Family Care settings require a live-in agreement that includes room and board arrangements and termination agreements. • Residential Care agreements must include specific provisions with regards to occupancy, voluntary and involuntary termination of placement (30-day), and notice of any changes in rates, physical plant, policies, or other services (90-day). • Assisted Living Licensing Regulations contemplate a participant's aging in place and outline the circumstances whereby someone may be asked to leave. Requirements include a written agreement and 30-day notice period and notice of any changes in rates, physical plant, policies, or other services (90-day). • Written plans of care, reviewed at least annually, are also required to address participant services, supports, and goals.	Alignment	Alignment	N/A (not a residential service)

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
place for each HCBS participant, and that the document *provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.*					
7. Each individual has privacy in their sleeping or living unit	**Adult Family Care Live-in Agreement** **Residential Care Home Licensing Regulations** Sec. X. 9.2(e-g) **Assisted Living Licensing Regulations** Sec. II. 3.2 Sec. XI. 11.1	• Adult Family Care placements are individually matched and allow for private or semi-private (no more than two) accommodations of the person's choosing. • Residential Care Level III licensing standards allow for private or semi-private rooms. Residents must not be required to pass through other bedrooms to reach their room, and assigned bedrooms are only to be used as personal sleeping and living quarters of assigned resident (s). • Assisted Living Residence licensing standards require residences to be homelike with private bedroom, private bath, and living space, kitchen capacity, and lockable door.	Alignment	Alignment	N/A (not a residential service)
8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	**CFC Program Manual** Sec. IV. 11 E. **Residential Care Home Licensing Regulations** Sec. IX **Assisted Living Licensing Regulations** Sec. 11.2 (b), (f)	• Person-centered planning and participants' rights agreements stress privacy and planning for personal preferences; however, there is no specific reference to lockable doors. • Adult Family Care materials do not specify lockable door standards but do require that written agreements and care plans outline all shared living arrangements. • Residential Care Level III licensing standards do not specify lockable units. • Assisted Living Residence licensing standards require lockable units.	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences and needs	Partial Residential Care Home Licensing Regulations are silent regarding lockable door requirements	N/A (not a residential service)

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
9. Individuals sharing units have a choice of roommates in that setting	**CFC Program Manual** Sec. IV. 11 E. **Residential Care Home Licensing Regulations** Sec. IX **Assisted Living Licensing Regulations** Sec. 11.1	• Adult Family Care Guidelines only authorize 1- or 2-person homes based on person's choice. • Residential Care Level III licensing standards do not specify how semi-private placements are made. • Assisted Living residences are private occupancy unless the resident chooses to share the unit; any common areas must be available to residents at all times.	Alignment	Partial Residential Care Home Licensing regulations are silent regarding how roommates are assigned in semi-private situations	N/A (not a residential service)
10. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	**CFC Program Manual** Sec. IV. 11 E. **Residential Care Home Licensing Regulations** Sec. IX **Assisted Living Licensing Regulations** Sec. XI	• Adult Family Care Guidelines do not specify décor standards but do require written agreements and care plans to outline all shared living arrangements. • Residential Care Level III licensing standards do not specify standards for room décor. • Assisted Living Residence licensing standards are considered private lease units but do not specify standards for room décor.	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences	Silent	N/A (not a residential service)
11. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	**Residential Care Home Licensing Regulations** Sec. 7.1 (c)(4) **Assisted Living Licensing Regulations** Sec. X. 10.1 Sec. XI. 11.2 (b), 11.5 (a) **CFC Program Manual** Sec. IV. 11 E. 5 Standards for Adult Day Sec. I. A, B Sec. X. A, B, F5, Sec. XIII	• Adult Family Care Settings are required to provide for diet and nutrition based on the desires and preferences of the participant and must be documented in the written live-in agreement. • Residential Care Level III licensing standards provide for alternative meals on request but do not specify 24/7 access to food. • Assisted Living Residence licensing standards provide that the participant has his or her own unit and makes decisions about meals or purchases meal plans from the host facility. • Residential Care Home and Assisted Living Regulations provide that facilities that do offer common kitchens must make them available for participant use at all times. • Adult Day Services are structured daytime programs; however, the person has the right to refuse participation in daily activities and	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences	Partial Residential Care Homes offer meal plans and are required make options available as requested by participants. Regulations are silent on 24/7 access	Alignment

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
		request alternative snacks and meals.			
12. Individuals are able to have visitors of their choosing *at any time*	**CFC Program Manual** IV. 11 E. 10 **Residential Care Home Licensing Regulations** Sec. 6.5 **Adult Family Care Participant Rights** Sec 5	• Adult Family Care requirements provide that homes allow visitors as determined by the participant or legal representative, including the right to refuse visitors. Visiting times must be agreed on and specified in live-in agreement • Residential Care Homes must provide for private communications and allow visitors at least from 8 am to 8 pm or longer, and residents may make other arrangements with the home for visitors; residents are allowed to refuse any visitor. • Assisted Living Residences are considered private units. • Standards for Adult Day Service are silent on visitors	Partial Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences	Partial Residential Care Home Licensing regulations outline minimum standards (e.g., 8 am to 8 pm) not maximum	Silent
13. The setting is physically accessible to the individual	**CFC Program Manual** Sec. IV. 11. B 2, D 9 **Residential Care Home Licensing Regulations** Sec. 9.5 **Assisted Living Licensing Regulations** Sec. XI. 11.5 D	• Safety and Accessibility Inspections are required of all settings.	Alignment	Alignment	Alignment
14. Modification to HCBS Settings Requirements					

- To be eligible for the Choices for Care program, participants in the High and Highest Needs Group meet the standard for nursing facility level of care, and the use of a least restrictive home or community residential setting is based on needs, preferences, and choice. Persons requesting ERC services must receive a variance to be placed in those settings. Persons in the Moderate Needs Group are not eligible for an out-of-home residential benefit.
- Changes in setting from In-home to Adult Family Care or Enhanced Residential Care and Nursing Facility Care are based on choice, needs, and medical necessity.
- DAIL variance processes do not currently include request s to restrict or modify participant's choice, autonomy, or other rights; however, regulatory language as written permits DAIL to require more detailed documentation should there be a request for such a modification.
- DAIL guidance related to case management documentation, reasons for a change in setting, and/or other service planning changes does not consistently include specificity noted on the following pages.

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
(a) Identify a specific and individualized assessed need for modification	**CFC Regulations** Sec. XI **Standards for Adult Day Services** Sec. I. A, B Sec. X. B 8, G Sec. X.I D4	• ERC settings require variances and prior approval by DAIL for all CFC participants to ensure that the ERC facility can meet the needs of persons who meet nursing facility level of care. • Variances to any part of the CFC Regulation or policies can be requested from DAIL. Variances may only be based on the unique needs of the participants or be necessary modifications to address health, safety, and/or welfare concerns. Variances must include a description of the need, explanation of why the need cannot be met, and a description of the actual or immediate risk to health, safety, or welfare of the participant. Regulations are permissive of DAIL's requiring any additional detail needed to address the request. • Changes in setting, diet, or activity plans that do not require DAIL to approve a variance from regulation or policy are made with the input of the physician, participant and legal guardian, and/or team members of the participants choosing. • Standards for Adult Day services require participant assessment and written service plans.	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger
(b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan	**CFC Regulations** Sec. XI **Residential Care Home Licensing Regulations** Sec. III Sec. V. 5.3 **Assisted Living Residences Licensing Regulations** Sec. 4, 6.5	• Documentation is required, however guidance is broad	Silent	Silent	Silent

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
(c) Document less intrusive methods of meeting the need that have been tried but did not work	**CFC Regulations** Sec. XI **Residential Care Home Licensing Regulations** Sec. III Sec. V. 5.3 **Assisted Living Residences Licensing Regulations** Sec. 4, 6.5	• To be eligible for the Choices for Care program, participants in the High and Highest Needs Group meet a standard of nursing facility level of care. Service and Participant Choice drive all decision making related to place and type of services. • ERC settings require variances and prior approval by DAIL for all CFC participants to ensure that the ERC facility can meet the needs of persons who meet nursing facility level of care. • CFC participants in the High and Highest Needs groups all meet nursing facility level of care, but may choose to receive care in less restrictive settings; changes to a more restrictive nursing facility care would be by choice or as medically directed. • CFC participants choose where to receive services and the settings in which they live commensurate with their needs and level-of-care determination. • Case management standards support planning that promotes the least restrictive, most appropriate setting in accordance with needs and preferences. • Assisted Living Residences assume a person will age in place and only allow for termination of services in specific circumstances.	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger
(d) Include a clear description of the condition that is directly proportionate to the specific assessed need	**CFC Regulations** Sec. IV. B 1, B 2 Sec. VII. B 5, B 6 Sec. XI	• CFC participants in the High and Highest Needs groups all meet nursing facility level of care, but may choose to receive care in less restrictive settings; changes to a more restrictive nursing facility care would be by choice or as medically directed. • Changes are by participant choice or as medically directed. • Variance request must include a description of the need, explanation of why the need cannot be met, and a description of the actual or immediate risk to health, safety, or welfare of the participant. • CFC Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Silent	Silent	Silent

HCBS Settings Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement HCBS Setting Requirements	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day**
(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification	**CFC Regulations** Sec. XI. D	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • CFC Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Silent	Silent	Silent
(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated	**CFC Regulations** Sec. XI	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • CFC Regulations are permissive of DAIL's requiring any additional detail needed to address the request.	Silent	Silent	Silent
(g) Include informed consent of the individual	**CFC Regulations** Sec. XI	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • Adult Family Care Agreements include a consent. • Variance requests do not specify informed consent; however, they are permissive of DAIL's requiring any additional detail needed to address the request. • Adult Day Standards require informed consent in planning processes.	Partial Documentation requirements could be stronger	Partial Documentation requirements could be stronger	Alignment
(h) Include an assurance that interventions and supports will cause no harm to the individual	**CFC Regulations** Sec. XI **Residential Care Home Licensing Regulations** Sec. III, Sec. V. 5.3 **Assisted Living Residences Licensing Regulations** Sec. 4, 6.5	• Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders. • CFC Regulations and operations manuals include requirements for the protection of health and safety and are permissive of DAIL's requiring any additional detail needed to address the request.	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger	Alignment Documentation requirements could be stronger

Appendix B: Person Centered Planning Requirements and Vermont Regulation and Policy Crosswalk

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
1. Includes people chosen by the individual and led by person or legal rep where possible	**Choices for Care Regulations** Sec. VII. B 5 **CFC Program Manual** Sec. III. C 7 **Case Management Standards & Certification Procedures** Sec. IV. B, C, G, H, I **Case Management Action Plan Guide** **Standards for Adult Day Services** Sec. I. A, B Sec. X. A, B Sec. XI. D4	• CFC Regulation calls for person-centered planning and defines it as a process by which services are planned and delivered based on an individual's strengths, capacities, preferences, needs, and desired outcomes. • DAIL Case Management Certification Standards and the DAIL Case Management Action Plan Guide call for members of the person's choosing to be involved in the planning process as directed by the participant or legal guardian.	Alignment	Alignment	Alignment
2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions	**Choices for Care Regulation** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C. **Case Management Standards & Certification Procedures** Sec. IV. A, B, C **CFC Program Manual** Sec. III. C 7 Section IV. 10, 11 E 1 **Adult Family Care Participant Rights** **Adult Family Care Service Plan** (Consent Statement	• CFC regulations provide that persons receive information on all options available within the Choices for Care Program. • DAIL Clinical Care staff is required to discuss all available long-term care options as part of the application process. • DAIL Case Management Certification Standards and the DAIL Case Management Action Plan Guide call for participants to receive timely information and referral information and assistance in the service planning and monitoring process to ensure that needs are being met and goals pursued.	Alignment	Alignment	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	regarding options)				
3. Is timely, occurs at times and locations of convenience to the individual	**Case Management Standards & Certification Procedures** Sec. IV. F, I **Case Management Action Plan Guide**	• Case Management Certification Standards call for timely response to participants and for initial goals and objectives to be in place within 60 days of the participant's assessment. • Case Management Action Plan Guide does not address location.	Partial Guidance discusses participant direction but does not specify time and location arrangements	Partial Guidance discusses participant direction but does not specify time and location arrangements	Partial Guidance discusses participant direction but does not specify time and location arrangements
4. Reflects cultural considerations of the individual and is conducted by providing information in plain language and accessible to individuals with disabilities and persons who are limited English proficient	**Case Management Standards & Certification Procedures** Sec. IV. A, B, C, G, I **Case Management Action Plan Guide** **AHS Limited English Proficiency Policy** **Standards for Adult Day Services** Sec. I A, B Sec. X A, B Sec. XI D4 Sec. XII D2-5	• Case Management Certification Standards require service plans to respect participants' rights, strengths, values, and preferences and encourage them to create, direct, and participate in their written plan to the fullest extent possible. • Case Management Action Guide calls for plans to be written in 'Plain English' using terms and language that the participant can understand. • All units of government within the Agency of Human Services are also required to follow the Agency's policies and practices on assuring services are provided in an accessible manner for participants who have Limited English Proficiency.	Alignment	Alignment	Alignment
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants	**CFC Regulations** Sec. II. F; Sec. XII; Sec. XIII. B 2-4, C 3-5 **CFC Program Manual** Sec. III. C 5, C 6, C 16, C 18 **Case Management Standards & Certification Procedures** Sec. III. B, K	• CFC regulations call for a process for handling participant feedback, complaints, and disagreements. • CFC Universal Provider Standards and Case Management Certification Procedures require all providers to have conflict-of-interest procedures and to make those processes known to participants. • The CFC grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration.	Alignment	Alignment ERC specific conflict of interest standards could be strengthened due to the nature of the all-inclusive package.	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Sec. IV. L, M **Standards for Adult Day Services** Sec. IX. D	• Standards for Adult Day Services include requirements for conflict of interest.			
6. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan*, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.* In these cases, the State must *devise conflict of interest protections including separation of entity and provider functions within provider entities*, which must be approved by CMS. Individuals must be provided with *a clear and*	**CFC Regulations** Sec. XII Sec. XIII. B 2, B 3, B 4, B 5 **CFC Program Manual** Sec. III. C 5, C 6, C 16, C 18 **Case Management Standards & Certification Procedures** Sec. III. B, K Sec. IV. L, M **MCO Grievance and Appeal Rules**	• VT Statute provides for the designation and certification of Home Health Agencies, Area Agencies on Aging to serve specific geographic regions and populations. Participants may choose where to receive their case management services from among approved providers and may choose a single agency for all services. • VT Statute requires a Long-Term Care Ombudsman program. • DAIL has established Aging and Disability Resource Centers statewide for information and referral, options counseling, and assistance with understanding grievance and appeal rights. • VT legislature recently directed DAIL to eliminate potentially duplicative functions for persons receiving case management as part of all-inclusive Adult Family Care or Enhanced Residential Care services, and additional case management services from an AAA or Home Health provider. • CFC Universal Provider Standards and Case Management Certification Procedures require all providers to have conflict-of-interest procedures and to make those processes known to participants. • Participants choosing Adult Family Care receive case management from a host agency. The host agency is responsible for facilitating an acceptable match of shared living setting, contracting with the home provider on the participant's behalf, and developing a person-centered plan between the home provider and the recipient. The host agency is responsible for oversight of the care plan and following up on any client concerns with the home, plan, or other services.	Alignment	Partial Due to nature of the all-inclusive payment, persons who choose these living options are also choosing an all-inclusive service package that includes case management.	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
accessible alternative dispute resolution process		• Participants choosing ERC in a Residential Care Home or Assisted Living Residence receive an all-inclusive package of services that includes case management from the provider. • CFC regulations require a quality assurance/quality improvement process that includes provisions for a Long-Term Care Ombudsman; participant complaints, appeals, fair hearings, and feedback to DAIL; and provider performance monitoring. • The CFC grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration. • Case Managers cannot be financially responsible or related to the person.			
7. Offers informed choices to the individual regarding the services and supports they receive and from whom	**Choices for Care Regulations** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C. **Case Management Standards & Certification Procedures** Section IV. A, C **CFC Program Manual** Sec. III. C 7 Sec. IV. 11, E **Adult Family Care Training Materials** Goal and General Policies; Sec. 1. b-c; 2 b **Adult Family Care Participant Rights** **Adult Family Care Service**	• All Participants choose where to receive their long-term services and supports. • DAIL Clinical Care Coordinators are responsible for ensuring that recipients have made informed choices regarding where and from whom they receive services. • Adult Family Care host agencies are responsible for facilitating a person-centered plan between the home provider and the recipient that address all aspects of shared living and service provision. • CFC also offers self-management of services under the Flexible Choices option.	Alignment	Alignment	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Plan (Consent Statement)				
8. Includes a method for the individual to request updates to the plan as needed	**Case Management Standards & Certification Procedures** Sec. IV. B, F, G, I **Case Management Action Guide**	• Case Management Certification Standards call for case managers to provide timely response to participants' requests for assistance and to monitor progress and update participants' plans as needed and no less than annually. • The Certification Procedures and Action Guide require the regular review and updating of the plan as needed but do not specifically mention participant-initiated change.	Alignment	Alignment	Alignment
9. Records the alternative home- and community-based settings that were considered by the individual	**Adult Family Care Service Plan** (Consent Statement)	• CFC regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making; however, how and where documentation should occur is not specifically mentioned. • DAIL Case Management Action Plan Guide calls for the action plan to document the person's preferences, long- and short-term goals, and plans to address those goals. • Adult Family Care Service Plan includes consent and signature line noting that the participant was informed of all options.	Alignment	Alignment Documentation could be strengthened	N/A
10. Reflect that the setting in which the individual resides is chosen by the individual.	**CFC Regulations** Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f), A 2 (b), (c), (g); C **CFC Program Manual** Sec. III. C 7 Sec. IV. 11, D 8, E **Case Management Standards Certification Procedures** Sec. IV. C **Adult Family Care Service Plan** (Consent Statement)	• CFC regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making; however, how and where documentation should occur is not specifically mentioned. • DAIL Case Management Action Plan Guide calls for the action plan to document the person's preferences, long- and short-term goals, and plans to address those goals.	Partial Documentation could be strengthened	Partial Documentation could be strengthened	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
11. Reflect the individual's strengths and preferences	**Case Management Standards & Certification Process** Sec. IV. B, G, H, I, K	• CFC regulation and certification standards provide for participants' choice, strengths, and preferences and informed decision making; however, how and where documentation should occur is not specifically mentioned. • DAIL Case Management Action Plan Guide calls for the action plan to document the person's strengths, preferences, long- and short-term goals, and plans to address those goals.	Alignment	Alignment	Alignment
12. Reflect needs identified through functional assessments	**CFC Regulations** Sec. IV. B, C; Sec. V. C, D; Sec. VI; Sec. VII. B 1, B 3, B 5, B 6 **CFC Program Manual** Sec. IV. 11 D 8 **Case Management Standards & Certification Procedures** Sec. IV. B, G, H, I, J, K **Case Management Action Plan** **Standards for Adult Day Services** Sec. XI. D4	• CFC regulation and certification standards provide for service and person-centered plans to be based on functional assessments, strengths, preferences, and supports that maximize independence.	Alignment	Alignment	Alignment
13. Include individually identified goals and desired outcomes	**Case Management Standards & Certification Process** Sec. IV. H, I, J, K **CFC Program Manual** Sec. IV. 11 D 8 **Adult Family Care Training Materials** **Case Management Action**	• Case Management Certification Standards and Case Management Action Guide call for plans to reflect short- and long-terms goals and actions steps, persons responsible, and target dates.	Alignment	Alignment	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Plan **Standards for Adult Day Services** Sec. XI D4				
14. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports	**Case Management Action Plan** **Standards for Adult Day Services** Sec. XI. D4	• Case Management Certification Standards and Case Management Action Guide call for plans to reflect short- and long-terms goals and actions steps, persons responsible, and target dates. • Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan.	Alignment	Alignment	Alignment
15. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	**Case Management Standards & Certification Procedures** Sec. IV. B 3, K 9 **Assisted Living Licensing Regulations** Sec. IX. Negotiated Risk **Standards for Adult Day Services** Sec. IV. A Sec. XI. D4	• Case Management standards call for person-centered plans to address all needs and also call for assessment of acceptable risk and written agreements as needed. • Assisted Living Licensing Standards provide for Negotiated Risk Agreements as needed.	Alignment	Alignment	Alignment
16. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her (written in	**Case Management Action Plan Guide** **AHS Limited English Proficiency Policy**	• Case Management Action Guide calls for plans to be written in 'Plain English' using terms and language that the participant can understand. • All units of government within the Agency of Human Services are also required to follow the Agency's policies and practices on assuring services are provided in an accessible manner for participants who	Alignment	Alignment	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)		have Limited English Proficiency.			
17. Identify the individual and/or entity responsible for monitoring the plan	**Case Management Action Plan Guide**	• Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan.	Alignment	Alignment	Alignment
18. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation	**Case Management Action Plan Guide**		Alignment	Alignment	Alignment
19. Be distributed to the individual and other people involved in the plan	**Case Management Action Plan Guide**	• Case Management Action Plan calls for distribution to the participant and members of the planning team and/or family with the participant's consent.	Alignment	Alignment	Alignment
20. Include those services, the purpose or control of which the individual elects to self-direct	**Case Management Action Plan Guide** **CFC Program Manual** Sec. IV. 10	• Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan. • CFC Flexible Choices provides for additional guidance regarding self-directed care options.	Alignment	Alignment	Alignment
21. Prevent the provision of unnecessary or inappropriate services and supports	**CFC Regulations** Sec. VII. B 6 **CFC Program Manual** Sec. III. C 4, C 8, C 17 Sec. IV. 8 E	• CFC Program manual requires providers to ensure services are coordinated and responsive to the individual's needs and are not duplicative or unnecessary.	Alignment	Alignment	Alignment

Person-Centered Planning Process Requirements: VT Policy Assessment			Policy Alignment		
42 CFR HCBS Requirement - Person Centered Process	**Choices For Care Policy, Rules, Guidelines**	**VT Statutory or Policy Guidance**	**Adult Family Care**	**Enhanced Residential Care**	**Adult Day Programs**
	Sec. IV. 11 I				
22. The person-centered service plan must be reviewed, and revised upon reassessment, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual	**Case Management Standards & Certification Procedures** Sec. IV. B, F, G, I **Case Management Action Guide** **Residential Care Home Licensing Regulations** Sec. 5.7, 5.9(c) **Assisted Living Residence Licensing Regulations** Sec. 6.7	• Case Management certification standards and action plan guide note that plans are required to be reviewed as needed or requested by the participants, but no less than annually. • Residential and ERC licensing standards require assessments, plans, and review, but do not specify periodicity.	Alignment	Alignment	Alignment
Modifications to any of the home and community setting requirements are documented: See settings rule crosswalk in Appendix A.					

Attachment 3c - DDSD HCBS Work Plan

Developmental Disabilities Services Division HCBS Work Plan

Regulation: Settings Requirements **This is the wording of the new rules where we can be more specific in what we have in writing for our Vermont system.**	**Steps that we should take:**
Commensurate with a persons individualized plan, needs and abilities the setting – The setting is integrated in and supports full access to community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS.	The Heartbeet setting includes multiple group and shared living options on one campus. Hannah Schwartz, Executive Director, is aware of the new rules and we have talked about joining us in determining ways of aligning the concept of a home as specified in the new rules with how that experience is created at Heartbeet. If the people who live there want to use their HCBS funding to support the cost, we will notify CMS that this location will fall under the category of "heightened scrutiny". It will require additional onsite review and determination of compliance.
	We only need to make small adjustments in SEVEN areas of the Vermont rules to make them more specific
Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	For Group Community Supports (Provider controlled settings) there are no service specific definitions or guidelines.

Facilitates individual choice regarding services and supports, and who provides them	For Group Community Supports that are provided in provider controlled settings there are no service specific guidelines on this topic.
The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.	Policies for Shared Living (1 – 2 persons) and Staffed Living (1 – 2 persons) do not address this requirement.
Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	None of the regulations for residential settings stipulate or otherwise provide guidance on who has keys to various settings.
Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	Documentation in the guidelines for all residential settings could be stronger.
Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	

	For community supports in provider controlled settings there are no service specific guidelines
Behavioral intervention programs "(c) Document less intrusive methods of meeting the need that have been tried but did not work"	Documentation standards in the DD Act could be stronger on this point.
Regulation: Person-Centered Planning	**Steps that we should take:**
<u>The person-centered plan should</u>: Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. <u>Case Management should not be influenced by a conflict of interest</u>: Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to	The population density and rural aspects of our state presents conditions where the current structure of having Designated Agencies provide both case management and services is likely to be supported by CMS given the stipulation that there is a resulting lack of an alternative "willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area". However, our system needs to be vigilant in addressing potential conflict of interest by establishing protocols and protections for people who receive support.

provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process Offers informed choices to the individual regarding the services and supports they receive and from whom	
	The rules need to be revised to ADD this item in person-centered plans
Records the alternative home- and community-based settings that were considered by the individual	Guidelines do not address this element.

Attachment 4 - Population Health Plan Overview Presentation

POPULATION HEALTH PLAN

Draft Overview for Discussion and Comment

October 2016

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?

INTRODUCTION AND BACKGROUND

"We need to shift from focusing on health care to focusing on health."

Karen Hein, MD

The Population Health Plan…

- Leverages and builds upon existing priorities, strategies, and interventions included in Vermont's State Health Improvement Plan (SHIP) and other state initiatives

- Addresses the integration of public health and health care delivery

- Leverages payment and delivery models as part of the existing health care transformation efforts

Building on State Innovation Models (SIM/VHCIP) and the State Health Improvement Plan (SHIP)

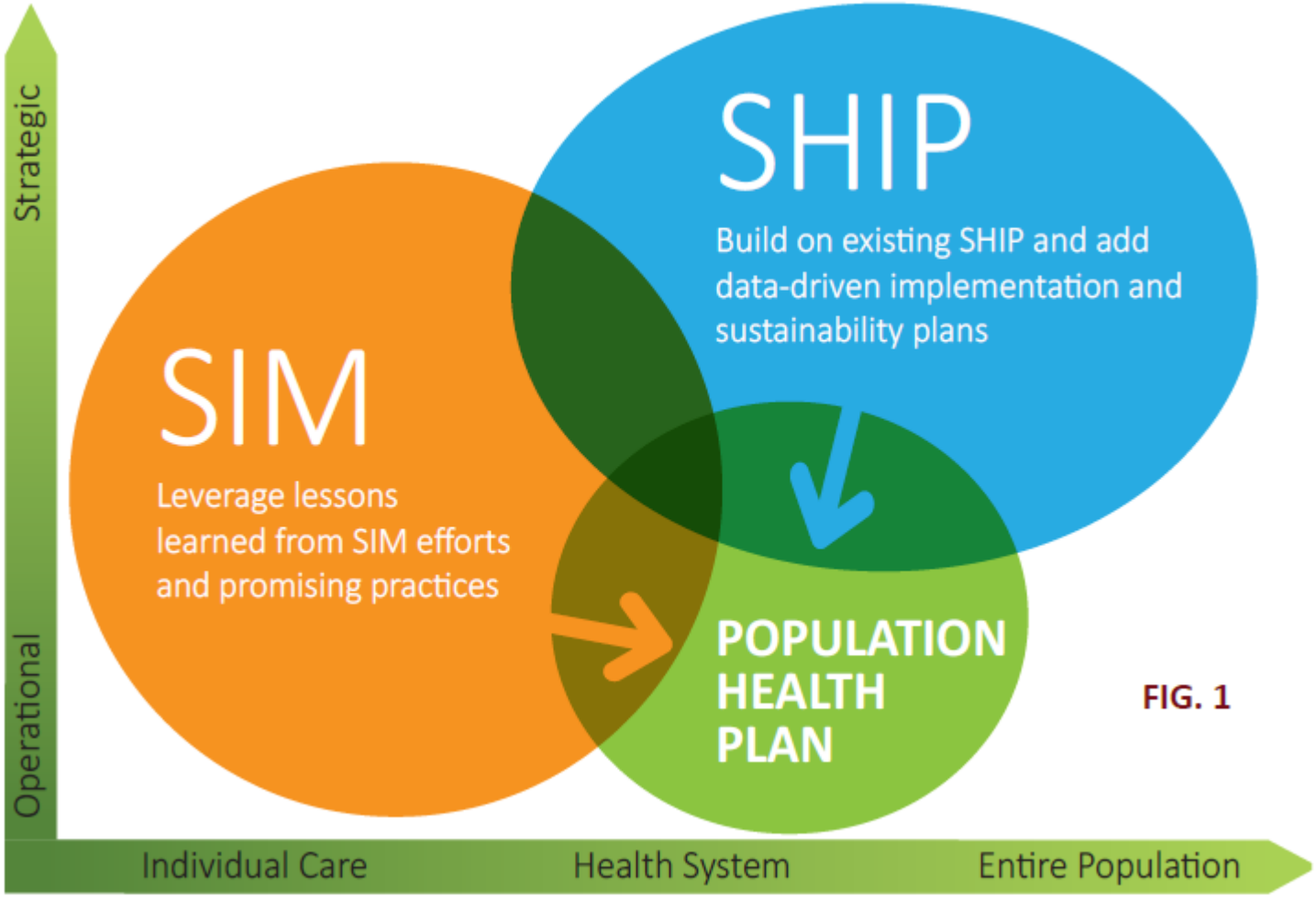


FIG. 1

FIVE PRINCIPLES FOR IMPROVING POPULATION HEALTH

Principles for Improving Population Health

1. Use Population-Level Data on Health Trends and Burden of Illness to Identify Priorities and Target Action.

- Consider the health outcomes of a group of individuals, including the distribution of such outcomes within the group, in order to develop priorities and target action.

- Focus on identified state priorities given burden of illness, known preventable diseases, and evidence-based actions that have proven successful in changing health outcomes.

Principles for Improving Population Health

2. Focus on Prevention, Wellness, and Well-Being at All Levels – Individual, Health Care System, and Community.

- Focus on actions taken to maintain wellness rather than solely on identifying and treating disease and illness.

- Particular focus should be on strategies to address mental health issues, substance use disorder, and long-term services and supports. Prevention can be woven into all levels of the health system to improve health outcomes.

Principles for Improving Population Health

3. Address the Multiple Contributors to Health Outcomes.

- Identify the circumstances in which people are born, grow up, live, work, and age. These circumstances are in turn shaped by a wider set of forces, or root causes, including economics, social policies, and politics.

- Consider risk factors that lower the likelihood of positive outcomes while creating a higher likelihood of negative or socially undesirable outcomes. Consider protective factors that enhance the likelihood of positive outcomes while lessening the likelihood of negative consequences from exposure to risk.

Principles for Improving Population Health

4. Community Partners Engaged in Integrating Clinical Care and Service Delivery with Community-Wide Population Prevention Activities.

- Build upon existing infrastructure (Community Collaboratives, Accountable Care Organizations, and public health programs), to connect a broad range of community-based resources, and to address the interrelationships among physical health, mental health, and substance abuse.

Principles for Improving Population Health

5. Create Sustainable Funding Models Which Support and Reward Improvements in Population Health, including Primary Prevention and Wellness.

- Direct savings, incentives, and investments in efforts aimed at primary prevention, self-care, and maintaining wellness.

- Ensure funding priorities explicitly demonstrate spending and/or investments in prevention and wellness activities.

RECOMMENDATIONS

Policy Levers

- The Population Health Plan identifies recommendations for integrating population health strategies and goals into future health reform activities through four categories of policy levers:

  - Governance Requirements;
  - Care Delivery Requirements and Incentives;
  - Metrics and Data; and
  - Payment and Financing Methodologies.

Lever: Governance Requirements

- Regulatory or other actions intended to include entities that have the authority, data/information, and strategies to impact the multiple factors that contribute to positive health outcomes.

- This action includes appointing public health and prevention (or other sectors not traditionally included in health care decision-making) on governing bodies, including boards or advisory structures, to encourage cross-sector partnership and collaboration.

Lever: Governance Requirements

- Specific activities at the State level could include:
  - Embedding governance requirements in Medicaid contracts with ACOs and other providers.
  - Requiring ACOs, through Act 113 of 2016, to include public health and prevention leaders in their governing entities.
  - Create a statewide public/private stakeholder group, similar to the Population Health Work Group, that recommends activities to State health policy leadership.
  - Expand partnerships to other sectors that impact health. Build upon the efforts of the Governor's Health in All Policies Task Force.

Lever: Governance Requirements

- Specific activities at the Community/Regional Level could include:
  - Expansion of efforts to expand partnerships to other sectors that impact health at the community or regional levels including housing, business, city and town planners, among others.
  - Expand existing Community Collaboratives so they are able to meet all of the components of Accountable Communities for Health.

Lever: Care Delivery Requirements and Incentives

- Care delivery requirements and incentives can demand or support health care providers and organizations in changing their behavior to support population health goals, either through specific changes or more broadly.
- Current: Vermont is utilizing state policy levers to create the foundation for payment reforms and care delivery reforms to move our health care system from acute care to more coordinated care.
- Future: Expand upon the regional integration started with the Community Collaboratives.

SPOTLIGHT: Accountable Communities for Health

- An aspirational model; an ACH is accountable for the health and well-being of the entire population in its defined geographic area. It supports the integration of high-quality medical care, mental health services, substance use treatment, and long-term services and supports, and incorporates social services. It also supports community-wide primary and secondary prevention efforts.
- ACHs explicitly build on the governance structures and partnerships developed by the Community Collaboratives, bringing in a new set of partners to integrate population health and prevention (including VDH, public health and community prevention coalitions, and additional partners from the social and community services sector).

Lever: Care Delivery Requirements and Incentives

1.0 Acute Care System

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

2.0 Coordinated Seamless Health Care System

Outcome Accountable Care

- Person-centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventative care

3.0 Community Integrated Health Care System

Community Integrated Health Care

- Healthy population-centered
- Population health-focused strategies
- Integrated networks linked to community resources capable of addressing psychosocial/economic needs
- Population-based reimbursement
- Learning organization that is capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

Lever: Care Delivery Requirements and Incentives

- Regulatory oversight through state processes to direct the overall flow and distribution of health resources within the State.
  - Certificate of Need program, Health Resource Allocation Plan, Insurance Rate Review, Hospital Budget Review, Professional Licensure, and contracting can help the State
  - Expectations within regulatory processes and contract vehicles that require entities to demonstrate how they will meet the components of Healthy Vermonters 2020, the All-Payer Model population health measures, and the Vermont Model of Care.

Lever: Care Delivery Requirements and Incentives

- Specific activities at the Community/Regional Level could include:
  - Incentivize Community Collaboratives to develop into Accountable Communities for Health which include community-wide primary prevention efforts which affect broad policy changes, key community infrastructure, and which require partnerships with a broader set of partners.
  - Utilize *Prevention Change Packets* – developed by VDH in collaboration with OneCare – to assist clinical and community providers, Community Collaborative leaders, and public health partners in working across systems to incorporate prevention strategies to improve population health.

Lever: Metrics and Data

- By integrating measurement of population health outcomes, Vermont can increase provider, policymaker, and community attention to priority community health concerns and the factors that drive them. In addition, Vermont can:
  - Require the collection of specific population health metrics;
  - Provide a list of metrics to choose from; and
  - Set guidelines around the need to move away from only using clinical, claims, and encounter-based metrics.

Lever: Metrics and Data

Inclusion of population health measures in state-level Payment and Delivery System Reform activities brings provider and policymaker attention to opportunities for increased prevention activities to improve population health outcomes.

- Continue to use of population health measures to drive statewide priority setting for improvement initiatives – for example, inclusion of screening measures for obesity, tobacco use, cancer into the payment and reporting quality measures for payment reforms.

- Track population health measures through the All-Payer Model Framework

Lever: Metrics and Data

- Specific activities at the Community/Regional Level could include:
  - Use data gathered by hospitals through the Federally required Community Health Needs Assessments (CHNAs) to determine the highest priority health needs of the community and develop an implementation strategy to meet those needs.
  - Provide regional-specific data, like that through the Blueprint Profiles to each hospital service area.

Lever: Payment and Financing Methodologies

- Payment methodologies – how health care providers and other organizations are paid for their work – and financing methodologies – how funds move through the health system— can incentivize particular behaviors by providers and the system as a whole.

- Two strategies to increase attention to population health goals or social determinants of health:
  - Value-based payment models for providers
  - Alternative financing models for population health and prevention (not grant-based)

Lever: Payment and Financing Methodologies

A conceptual model for sustainable financing includes…

1. **Diverse financing vehicles:** There has been the emergence of a diverse set of financing vehicles and sources of funds for population health interventions.
2. **Balanced portfolio of interventions:** Meeting the needs of a community requires implementing a combination of different programs, which are balanced in terms of their time horizon for producing results, their risk of failure, their scale, and their financing vehicle.
3. **Integrator or backbone organization:** The integrator brings together key community stakeholders to assess needs and build a consensus of priorities. It then builds the balanced portfolio over time, matching each intervention with an appropriate financing vehicle and an implementer organization.
4. **Reinvestment of savings:** One of the basic principles of long-term sustainability is capturing a portion of the savings of each intervention and returning it to the community for reinvestment. A community wellness fund is a useful repository for these captured savings.

Lever: Payment and Financing Methodologies

- The State can also include public health accountability requirements in the payment, monitoring, and evaluation activities for all state-level payment and delivery system reforms.
- Specific activities at the State level could include:
  - The Green Mountain Care Board can continue to support hospital investment in population health initiatives through its Community Health Needs Assessment Policy.
  - The Department of Health and Department of Vermont Health Access can continue to work together to identify opportunities to increase referral to population health management activities such as smoking-cessation classes and medications by allowing utilization of certain codes by clinicians for payment.
  - The Agency of Human Services, and its Departments, can incorporate mechanisms that encourage or require public health accountability in value-based contracts.
  - Tracking of population health measures through the All-Payer Model.

Lever: Payment and Financing Methodologies

- Regional or community-specific initiatives that foster financing of public health initiatives at the local level can be encouraged through local collaborations and prioritization of public health initiatives.
- Specific activities at the Community/Regional Level could include:
  - Pooling resources within a region to support a target a specific initiative like food security or ending homelessness.

MEASURING SUCCESSFUL PLAN IMPLEMENTATION

Measuring Successful Plan Implementation

- **We will know we are on the path to success when:**
  - Health system actions are primarily driven by data about population health outcomes; goals and targets should be tied to these statewide data and priorities identified in the State Health Improvement Plan.
  - The health system creates health and wellness opportunity across the care and age continuum and utilizes approaches that recognize the interconnection between physical health, mental health and substance use, and the underlying societal factors.
  - Payment and financing mechanisms are in place for prevention strategies in the clinical setting, through clinical/community partnerships, and for community wide infrastructure and action.
  - An expanded number of entities are accountable for the health of the community including health care providers, public health, community providers. The accountability is expanded to include others who affect health through their work on housing, economic development, transportation, and more, resulting in true influences on the social determinants of health.

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?