***VT Health Care Innovation Project***
***"Disability and Long Term Services and Supports" Work Group Meeting Agenda***
**Thursday, October 6, 2016; 10:00 PM to 12:30 PM**
***Elm Conference Room***
***Waterbury State Office Complex***
**Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343**

| Item | Time Frame | Topic | Relevant Attachments | Decision Needed? |
|---|---|---|---|---|
| 1 | 10:00 – 10:05 | **Welcome; Approval of Minutes**<br>Deborah Lisi-Baker | • Attachment 1a: Meeting Agenda<br>• Attachment 1b: Minutes from July 12, 2016 | Yes |
| 2 | 10:05 – 10:25 | **Home and Community-Based Rules/Independent Options Counseling**<br>Megan Tierney-Ward, Roy Gerstenberger, DAIL | • Attachment 2a: CFC Application of Federal Rules Reference Table<br>• Attachment 2b: CFC HCBS Work Plan<br>• Attachment 2c: CFC HCBS Final Alignment Report<br>• Attachment 2d: Developmental Disabilities HCBS Work Plan | |
| 3 | 10:25 – 10:50 | **DLTSS Sub-Analysis of ACO Performance Measures**<br>Alicia Cooper, DVHA | • Attachment 3a: DLTSS – ACO Quality Measures Year 1 Sub-Analysis, September 2016<br>• Attachment 3b: DLTSS – ACO Quality Measures Year 1 Sub-Analysis Spreadsheet, September 2016 | |
| 4 | 10:50 – 11:20 | **Medicaid Pathway Updates**<br>• **Mental Health/Substance Abuse/ Developmental Services**<br>Roy Gerstenberger, DAIL<br>• **Long Term Services and Supports/Choices for Care**<br>Bard Hill, DAIL, Julie Wasserman, AHS | • Attachment 4a: DS Overview of MH/SA/DS Medicaid Pathway<br>• Attachment 4b: Choices for Care/Model of Care Opportunities 9-21-16 | |

| | | | | |
|---|---|---|---|---|
| 5 | 11:20 – 11:50 | **All Payer Model including Next Gen Medicaid and Medicare ACO Programs**<br>Robin Lunge | • Attachment 5a: Vermont All-Payer Accountable Care Organization Model, September 28, 2016<br>• http://hcr.vermont.gov/engagement for additional reference materials | |
| 6 | 11:50 – 12:20 | **Population Health Plan/Accountable Communities for Health**<br>Heidi Klein, VDH | • Attachment 6a: Population Health Plan Overview<br>• Attachment 6b: Vermont Population Health Plan - September 2016 (for public comment) | |
| 7 | 12:20 – 12:30 | **Public Comment**<br>Deborah Lisi-Baker | **Next Meeting:**<br>• **Tuesday, November 1, 2016**, 10:00 am – 12:30 pm, Waterbury State Office Complex, Ash Conference Rm<br><br>**Final Meeting:**<br>• **Thursday, December 1, 2016,** 10:30 am – 12:00 Waterbury State Office Complex, Ash Conference Rm | |

# Attachment 1b - DLTSS Meeting Minutes 7-12-16

# *Vermont Health Care Innovation Project*
# *DLTSS Work Group Meeting Minutes*

## *Pending Work Group Approval*

**Date of meeting:** Tuesday, July 12, 2016, 10:00am-12:30pm, Elm Conference Room, Waterbury State Office Complex.

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome** | Deborah Lisi-Baker called the meeting to order at 10:05am. A roll call attendance was taken and a quorum was present.<br><br>Susan Aranoff moved to approve the January 2016 meeting minutes by exception. Julie Tessler seconded. The minutes were approved unanimously.<br><br>Susan Aranoff moved to approve the April 2016 meeting minutes by exception. Dale Hackett seconded. The minutes were approved unanimously. | |
| **2. DLTSS Sustainability Priorities** | Georgia Maheras led a discussion on VHCIP sustainability (Attachment 2). The Work Group will review the Sustainability Plan in November and will receive brief updates at every meeting through the Fall.<br>• As SIM activities wrap up, SIM sustainability planning activities will ramp up.<br>• A contractor, Myers and Stauffer, will support stakeholder convening specific to sustainability, will track all written and verbal feedback, and will draft plan documents for State review, including review by the new Administration in Winter/Spring 2017.<br>• Sustainability planning will include review of each SIM activity/work stream and identify whether activities were 1) one-time activities; 2) ongoing activities that will be continued by private-sector partners; or 3) ongoing activities that will be continued by the State.<br>• In addition, the Population Health Plan will come to all SIM Work Groups for review in October. This effort is driven by the Population Health Work Group.<br>• Georgia also noted that we received Performance Period 3 budget approval on June 29, in advance of the start of our third performance year on July 1. She thanked the SIM team and our federal partners for making this happen.<br>• Georgia also introduced Julie Corwin, a new Senior Health Policy Analyst at DVHA, who is joining the SIM team. | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | • Year 3 Operational Plan is posted on VHCIP website, June Status Reports are soon to be posted.<br><br>The group discussed the following:<br>• Dale Hackett asked: How will this process break down silos? How will this process create new silos or reinforce existing silos? Georgia replied that final reports from State-led evaluation will help us identify where we've removed silos or created new ones. Early evaluation results throughout the next twelve months will support early learning.<br>• Susan Aranoff asked: Will we replace the State evaluation director? Annie Paumgarten, GMCB Evaluation Director, left the project in June. Georgia replied that a candidate has accepted an offer to fill this position, and should hopefully start this month. Georgia noted that we expect additional departures over the next few months and commented that project leadership is planning for this. | |
| **3. Mental Health/ Substance Abuse/ Developmental Services Medicaid Pathway** | Selina Hickman provided an update on the Medicaid Pathway work specific to Mental Health, Substance Abuse, and Developmental Services.<br>• Objectives: Medicaid Pathway seeks to develop an organized delivery system for serving individuals and supporting integration across Medicaid – including physical health, mental health and substance abuse services, developmental services, and LTSS – a continuum of care across Medicaid services.<br>o The Vermont Model of Care (aka the DLTSS Model of Care), developed in part by this Work Group, is a foundation of this work. Erin Flynn noted that this was included in Selina's last presentation to this group.<br>o Population-based health and prevention are also foundational.<br>▪ Dale Hackett asked: How does this model balance care for the individual with improving population health? Selina replied that this model of care gets more closely at individuals' experience of care, but also focuses on measuring outcomes across populations and paying in ways that support providers in doing population-based interventions and approaches.<br>o Efficient operations and oversight – moving toward integrated services that span departments and programs requires a new approach to oversight.<br>o Alignment with All-Payer Model<br>• What does integration mean, who are the partners, and what does it look like when it happens? Pathway work group has put great effort into defining this, including variations – service coordination, partial integration, and full integration.<br>o Service Coordination – Providers continue to have separate organizations without broader governance, coordinate to provide care to patients and consult with one another to share expertise. We have this in some areas now.<br>o Partial Integration – Some integration, not necessarily a legal relationship. Focused on certain aspects of service delivery, i.e. specific populations, colocation of services. | **Julie Wasserman will share information on the Vermont Model of Care/DLTSS Model of Care to the group.**<br><br>**Selina Hickman will share draft governance outlines with the group.** |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | o Full Integration – Coming together in a formal legal arrangement with governance to set priorities, make decisions, and meet administrative needs like budgeting, measure collection and information technology, etc. Providers work together as a single team rather than making referrals.<br>o Barb Prine commented: Inability to hire and retain staff is the key issue for organizations providing services. Moving from service coordination to partial or full integration requires a significant look at what unintended consequences could be – for example, would this move services toward meeting Medicaid billing codes versus providing services individuals need. Selina replied that this is feedback she's heard. Integration is only part of this project, it needs to come with payment changes that ensure organizations are able to do their work. An evaluation is due to the Legislature this fall, and will hopefully build a business case for increasing funding in this area.<br>o Julie Tessler concurred: It's likely we could use the funds we have to serve people better, but it likely couldn't go farther because this sector is chronically underfunded. Julie also noted that DAs and SSAs already work well together. Blueprint-ACO UCCs, CHTs, and other collaborative efforts need to come together so we don't end up with silos for collaboration. Erin Flynn added that this is much of the work of the Integrated Communities Care Management Learning Collaborative.<br>o Kirsten Murphy commented: She agrees with the values we've discussed, but is concerned we haven't adequately built these values into our governance structures.<br>▪ What are we going to do about underserved populations?<br>▪ What level of independence do evaluators have from the system? Need strong independent oversight to ensure protection for individuals.<br>▪ How do we decide what happens with reinvestment dollars, and who decides? Bard Hill commented that many provides feel someone else is spending too much – we need to do analyses to identify where savings could occur and articulate how those savings will come out.<br>• Governance – The work group has developed draft system governance models by looking within the state and nationally. Work group is now comparing identified governance models/key elements to existing governance within communities (UCCs, IFS, or others).<br>• Next Steps – Currently two Medicaid Pathway work groups, with increasing efforts to overlap and combine efforts. Preparing to do an information gathering process to solicit feedback from any interested parties. This process will lay out a model and essential functions, and request that communities share how they would respond to the designs and structures developed separately.<br>o Barb Prine commented that this is a great concept, but Vermont is trying to do a lot and we don't know what's working yet (ex/IFS, Next Generation ACO model).<br>• Four consumers are joining the work groups this summer, including one person from the mental health services world and three people from the developmental services world.<br>• Interested parties should contact Selina to receive materials and/or listen to meetings. | |
| **4. Frail Elders Project** | Cy Jordan and Erica Garfin presented on the Frail Elders project. | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | • This project started with an idea from Anya Rader Wallack, which resulted in two white pages presented to GMCB in late 2013. Two SIM-funded projects grew from this: A project looking at reducing unnecessary lab testing which has shown great results, and the Frail Elders Project. Both projects ended in June.<br>• Frail Elders project focused on two service areas, Randolph and Little Rivers.<br>• Initial focus on frailty, but expanded beyond that – "We are all one fall away from frailty."<br>• Combined lit review, key informant interviews with providers from across the care continuum, focus groups, and quantitative analyses using claims data and comparing Vermont surveys to national survey data.<br>• Cy walked through project findings.<br>  o Medicare benefits aren't meeting the needs of frail elders – but changing benefits to be more robust would not necessarily solve the issues frail elders have identified. Social needs are key factors. | |
| **5. All-Payer Model, including Next Gen Medicaid and Medicare ACO Programs** | Michael Costa provided an update on the All-Payer Model project.<br>• The project continues to progress. No agreement has been reached yet between the State and CMMI.<br>• Continued efforts to prepare for payment and delivery system reform whether or not we have a Medicare waiver. DVHA RFP has resulted in selection of OneCare Vermont as the apparently successful bidder in the DVHA ACO Procurement Contract. Contract negotiations have launched, and depend on parties reaching agreement on contract terms and a robust readiness review to ensure an ACO can meet the terms of the contract starting on 1/1/2017. Working assumption is that we will move toward capitated payment with robust quality measurement.<br>• How will this really work? This is provider-led reform. The State has asked ACO to tell the State what services they would like to provide and how they propose to do so. Can't say much about how this will play out since contract is in active negotiation. Note that recent announcement stated that Vermont Care Organization (merged ACO) is going to come to fruition as a combination of all ACOs. Through contract negotiations, DVHA can work with ACO to get more information about how they propose to make progress.<br><br>The group discussed the following:<br>• Julie Tessler noted that her understanding is that OneCare and CHAC will merge but that CHAC will continue to take non-risk bearing contracts; OneCare will take on risk-bearing contracts. Will ACOs cover all DVHA beneficiaries or just those attributed to ACOs?<br>  o Michael replied that this is his understanding. Not all providers are ready to take on downside risk – this structure will allow VCO to build two different risk tracks, and allow some providers to build additional readiness to take on downside risk. The DVHA RFP is separate from this – DVHA asked applicants to suggest a risk corridor, with the idea that risk arrangements between ACOs and providers could vary.<br>  o The DVHA contract will cover only ACO-attributed lives; providers will be paid FFS as they are today for non-attributed lives. One big question for contract negotiations with OneCare will be how many attributed lives they bring (just OneCare, or OneCare plus CHAC). Additionally, Medicare flexibilities embedded in Next Generation model apply only to providers participating in a Next Gen ACO and | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | attributed lives. Michael noted that nothing about the Medicare benefit package will change, but that the State and Federal government have a keen interest in assessing whether participation changes beneficiary experience.<br>• Barb Prine asked: How would downside risk work for largely Medicaid-funded organizations?<br>o Michael replied that if GMCB set Medicare rates, some would likely stay FFS – some service sectors and services require more funding, not less. It's not an assumption that every organization will take on downside risk, risk should be appropriate for organization.<br>o One theory of APM is that financial caps on system as a whole will help push funds to currently under-resourced service areas that can help drive down unnecessary utilization.<br>o Julie Tessler commented: Populations like developmental disabilities are not necessarily medically high-risk, but we still need to provide them with services to support full community engagement and full lives. Michael replied that this is a long-term investment with a long-term payoff – savings won't be reaped in one Legislative session or out fiscal year. Increased investments in Medicaid will come more easily after initiatives like the All-Payer Model and Medicaid Pathway start to show financial benefits.<br>• Michael described the State's discussions with CMMI related to potential scale of this model. CMMI wants a model to be statewide – to include the vast majority of Medicare and Medicaid lives in Vermont over time. The State has levers to pull new providers and beneficiaries into the model, including benefit enhancements; reduced administrative barriers (avoiding MIPS and MACRA measurement requirements and payment decreases by participating in qualified alternative payment models and receiving a bonus); predictable (allow providers to predict revenues and encourage Legislature to provide payment increases over time); and sustainable – and of course improving access and quality. In addition, this will connect to population health measurement and all of the work VDH does to hopefully prevent chronic illness long-term.<br>o Kirsten Murphy noted there is a tension when the Federal government is using complex quality measurement as a punishment. How will this balance with consumer protection? Michael noted that this is a continuous tension – we know measurement is onerous for providers, but we also know it's critical for accountability and consumer protection. We must ensure quality, access, and consumer protection, but to do this in a way that doesn't detract from providers doing their jobs.<br>o Julie Tessler agreed that quality and access measures are critical when payments are lump-sum, but if we start without a level playing field (some sectors underfunded), we are disadvantaging some key sectors. Michael replied that CMMI wanted Medicaid-funded home and community-based services to be under financial caps from the start, but the State refused because that sector has been underfunded – we need to increase investment and grow readiness, including hopefully investment from well-resourced parts of the system as the incentive to invest in home- and community-based services increases.<br><br>Michael will return at the group's next meeting to continue this discussion. | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **6. Updates** | a) *LTSS Choices for Care Medicaid Pathway*: Bard Hill noted that HCBS services are growing quickly nationally as states move people and spending out of higher cost institutional services – he noted that this may link to Michael's earlier point about whether HCBS should be included in APM financial caps. Julie Tessler added that this service sector has achieved a great number of savings already – how can it get credit for this?<br>• Interested parties are welcome to come to the LTSS/Choices for Care Medicaid Pathway Work Group meeting tomorrow. Contact Julie Wasserman for more information.<br>• DAs/SSAs/Developmental Services have a second work group.<br><br>b) *DLTSS Data Gap Remediation Project*: Larry Sandage and Holly Stone provided a brief update on this project, which seeks to connect Home Health Agencies to the VIE through both interfaces and through VITLAccess. The project is still in the discovery phase, with main body of work to start soon. This project was initially intended to include AAAs, but this project area has run into federal policy roadblocks and is still in discovery. | |
| **7. Public Comment/Next Steps** | Public Comment:<br>• Barb Prine commented that Jackie Majoros and Trinka Kerr are both leaving Legal Aid, and invited interested applicants to apply.<br>• Julie Tessler noted that Vermont Care Partners also has an opening and asked interested applicants to apply.<br><br>**Next Meetings:**<br>• Thursday, October 6, 2016, 10:00am-12:30pm, Cherry Conference Room, Waterbury State Office Complex<br>• Tuesday, November 1, 2016, 10:00am-12:30pm, Ash Conference Room, Waterbury State Office Complex | |

# VHCIP DLTSS Work Group Member List

Sue 1° Julie T 2° Sue 1° Dale 2°

| Member | | Member Alternate | | December Minutes | January Minutes | April Minutes | 12-Jul-16 |
|---|---|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | | | | Organization |
| Susan | Aranoff ✓ | | | | | | AHS - DAIL |
| Molly | Dugan ✓ | | | | | | Cathedral Square and SASH Program |
| Patrick | Flood | | | | | | CHAC |
| Mary | Fredette ✓ | | | | | | The Gathering Place |
| Joyce | Gallimore | | | | | | Bi-State Primary Care |
| Martita | Giard | Susan | Shane ✓ | | | | OneCare Vermont |
| Joy | Chilton | | | | | | Home Health and Hospice |
| Dale | Hackett ✓ | | | | | | Consumer Representative |
| Mike | Hall | Angela | Smith-Dieng ✓ | | | | Champlain Valley Area Agency on Aging |
| Jeanne | Hutchins | | | | | | UVM Center on Aging |
| Pat | Jones ✓ | ~~Richard~~ | ~~Slucky~~ | | | | GMCB |
| Dion | LaShay ✓ | | | | | | Consumer Representative |
| Deborah | Lisi-Baker ✓ | | | | | | SOV - Consultant |
| Sam | Liss | | | | | | Statewide Independent Living Council |
| Jackie | Majoros | Barbara | Prine ✓ | | | | VLA/Disability Law Project |
| Madeleine | Mongan | | | | | | Vermont Medical Society |
| Kirsten | Murphy ✓ | | | | | | Developmental Disabilities Council |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Nick | Nichols | | | | | | AHS - DMH |
| | | | | | | | |
| Ed | Paquin ✓ | | | | | | Disability Rights Vermont |
| | | | | | | | |
| Eileen | Peltier | | | | | | Central Vermont Community Land Trust |
| | | | | | | | |
| Paul | Reiss | Amy | Cooper | | | | Accountable Care Coalition of the Green Mountains |
| | | | | | | | |
| Jenney | Samuelson | Craig | Jones | | | | AHS - DVHA |
| | | | | | | | |
| Rachel | Seelig | Trinka | Kerr | | | | VLA/Senior Citizens Law Project |
| | | | | | | | |
| Julie | Tessler ✓ | Marlys | Waller | | | | DA - Vermont Care Partners |
| | | | | | | | |
| Julie | Wasserman ✓ | | | | | | AHS - Central Office |
| | | | | | | | |
| Jason | Williams | | | | | | UVM Medical Center |
| | ~~26~~ | | 8 | | | | |

~~26~~ ~~25~~ 24

Quorum achieved ✓

| | Meeting Name: | VHCIP DLTSS Work Group Meeting | |
|---|---|---|---|
| | Date of Meeting: | July 12, 2016 | |
| | First Name | Last Name | |
| 1 | Susan | Aranoff | Not |
| 2 | Debbie | Austin | |
| 3 | Ena | Backus | |
| 4 | Susan | Barrett | |
| 5 | Bob | Bick | |
| 6 | Denise | Carpenter | |
| 7 | Alysia | Chapman | |
| 8 | Joy | Chilton | |
| 9 | Amy | Coonradt | |
| 10 | Amy | Cooper | |
| 11 | Alicia | Cooper | |
| 12 | Michael | Costa | Here |
| 13 | Molly | Dugan | Phone |
| 14 | ~~Patrick~~ | ~~Flood~~ | |
| 15 | Erin | Flynn | Here |
| 16 | Mary | Fredette | Phone |
| 17 | Lucie | Garand | |
| 18 | Christine | Geiler | |
| 19 | Martita | Giard | |
| 20 | Dale | Hackett | Phone |
| 21 | Mike | Hall | |
| 22 | Carolynn | Hatin | |
| 23 | Selina | Hickman | Here |
| 24 | Bard | Hill | Here |

| | | | |
|---|---|---|---|
| 25 | Jeanne | Hutchins | |
| 26 | Craig | Jones | |
| 27 | Pat | Jones | phone |
| 28 | Margaret | Joyal | |
| 29 | Joelle | Judge | here |
| 30 | Trinka | Kerr | |
| 31 | Sarah | Kinsler | here |
| 32 | Tony | Kramer | |
| 33 | Andrew | Laing | |
| 34 | Kelly | Lange | |
| 35 | Dion | LaShay | phone |
| 36 | Deborah | Lisi-Baker | here |
| 37 | Sam | Liss | |
| 38 | Carole | Magoffin | here |
| 39 | Georgia | Maheras | here |
| 40 | Jackie | Majoros | |
| 41 | Lisa | Maynes | |
| 42 | ~~Madeleine~~ → | ~~Mongan~~ | |
| 43 | Mary | Moulton | |
| 44 | Kirsten | Murphy | here |
| 45 | Nick | Nichols | |
| 46 | Miki | Olszewski | |
| 47 | Ed | Paquin | here |
| 48 | ~~Annie~~ → | ~~Paumgarten~~ | |
| 49 | Eileen | Peltier | |
| 50 | John | Pierce | |
| 51 | Luann | Poirer | |

| | | | |
|---|---|---|---|
| 52 | Barbara | Prine | here |
| 53 | Paul | Reiss | |
| 54 | Virginia | Renfrew | |
| 55 | Jenney | Samuelson | |
| 56 | Suzanne | Santarcangelo | here |
| 57 | Rachel | Seelig | |
| 58 | Susan | Shane | phone |
| 59 | Julia | Shaw | |
| 60 | ~~Richard~~ | ~~Slusky~~ | |
| 61 | Angela | Smith-Dieng | here |
| 62 | Holly | Stone | here |
| 63 | Beth | Tanzman | |
| 64 | Julie | Tessler | here |
| 65 | Bob | Thorn | |
| 66 | Beth | Waldman | |
| 67 | Marlys | Waller | |
| 68 | ~~Nancy~~ | ~~Warner~~ | |
| 69 | Julie | Wasserman | here |
| 70 | Kendall | West | |
| 71 | James | Westrich | |
| 72 | Jason | Williams | |
| 73 | Scott | Whittman | |
| 74 | David | Yacovone | |
| 75 | Marie | Zura | |

Kamy Sandage - here
Julie Corwin - here
Cy Jordan - here

Erica Garfin - here

# Attachment 2a - 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.<br><br>(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 2b - CFC HCBS 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

<table>
<tr><th>Regulation: Settings Requirements</th><th>Findings</th><th>Proposed Improvements/Action Steps</th></tr>
<tr><td>#8. AFC Setting: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors</td><td rowspan="4">AFC service plans and live-in agreements would benefit from more specific guidance regarding participant preferences and needs.<br><br>Standards for AD services are silent on visitors<br><br>#8, #10 and #11 are not applicable to AD since it is not a residential option.</td><td rowspan="5">a. DAIL to provide a self-assessment tool to Adult Family Care and Adult Day providers.<br>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<br>c. DAIL to update CFC Agreement for Live-in Care. http://ddas.vt.gov/ddas-programs/cfc-live-in-requirements.<br>d. DAIL to update AFC Participant Rights to reflect regulatory requirements.<br>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.<br>f. DAIL to solicit stakeholder feedback on updated documents.<br>g. DAIL to incorporate feedback into documents.</td></tr>
<tr><td>#10. AFC Setting: Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement</td></tr>
<tr><td>#11. AFC Setting: Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.</td></tr>
<tr><td>#12. AFC & AD Settings: Individuals are able to have visitors of their choosing at any time</td></tr>
<tr><td>#14. AFC & AD Settings: Modification to HCBS Settings Requirements</td><td>AFC and AD provider documentation requirements could be stronger regarding modifications to the settings requirements.</td></tr>
</table>

| Regulation: Settings Requirements | Findings | Proposed Improvements/Action Steps |
|---|---|---|
| | | h. DAIL to publish revised documents and distribute to stakeholders.<br>i. DAIL to incorporate related elements of consumer experience of care into the DAIL annual consumer survey<br>j. DAIL to provide training and technical assistance to providers and stakeholders as needed.<br>k. AHS, DAIL and DVHA to evaluate results of the provider self-assessment tools.<br>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<br><br>***#10. HB & AFC Settings:*** Reflect that the setting in which the individual resides is chosen by the individual.<br><br>***#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.<br><br>Documentation could be strengthened. | a. DAIL to provide a self-assessment tool to Case Management and Adult Family Care providers.<br>b. DAIL, AHS and DVHA to evaluate results of the provider self-assessment tools.<br>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.<br>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- |

| Regulation: Person-Centered Planning | Findings | Proposed Improvements/Action Steps |
|---|---|---|
| | | policies/policies-cfc/policies-cfc-highest/section-iv-11-adult-family-care<br>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.<br>f. DAIL to solicit stakeholder feedback on updated documents.<br>g. DAIL to incorporate feedback into documents.<br>h. DAIL to publish revised documents and distribute to stakeholders.<br>m. DAIL to provide training and technical assistance to providers and stakeholders as needed.<br>n. DAIL to incorporate related elements of consumer experience of care into the DAIL annual consumer survey.<br>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.<br><br>Residential Care Home Licensing Regulations are silent regarding lockable door requirements<br>Residential Care Home Licensing regulations are silent regarding how roommates are assigned in semi-private situations<br><br>Residential Care Home Licensing regulations are silent on the topic of furnishing and décor.<br>Residential Care Homes offer meal plans and are required make options available as requested by participants. Regulations are silent on 24/7 access | a. DAIL to provide a self-assessment tool to ERC providers.<br>b. DAIL, AHS and DVHA to evaluate results of the provider self-assessment tools.<br>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.<br>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<br>e. DAIL Solicit stakeholder feedback on revised documents.<br>f. DAIL to publish revised final documents.<br>g. Training and technical assistance providers as needed.<br>h. DAIL to incorporate revised standards into regulatory and quality review and activities |
| ***#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 | | |

| Regulation: Settings Requirements | Findings | Proposed Improvements/Action Steps |
|---|---|---|
| ***#12. ERC Setting:*** Individuals are able to have visitors of their choosing *at any time* | Residential Care Home Licensing regulations outline minimum standards (e.g., 8 am to 8 pm) not maximum<br><br>Documentation requirements could be stronger. | through the Division of Licensing and Protection and Adult Services Division.<br>i. DAIL to coordinate quality and licensing review activities with DVHA and AHS quality assurances under the Global Commitment Comprehensive Quality Plan (CQP). |
| ***#14. ERC Setting:*** Modification to HCBS Settings Requirements | | |

| 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 | 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 |
|---|---|---|
| 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 | | |
| ***#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 2c - 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**

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## ***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<br>• Licensing reapplications are required annually<br>• Revisions may also impact providers not involved with the Choices for Care or Medicaid program<br>• Regulation changes do not guarantee quality monitoring and improvement processes<br>• 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<br>• Standards could engage ERC providers in quality oversight and improvement planning<br>• 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<br>• 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<br>• 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<br>• 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:<br>• Person-centered planning checklist for case management and ERC providers<br>• Sample AFC live-in agreements<br>• Sample Residential agreements<br>• Participant handbooks<br>• Case Management Plan Action | • Updating sample templates could more clearly define State expectations for all settings regardless of type<br>• Checklist would provide opportunity for performance monitoring and more direct quality improvement planning<br>• 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**<br>Sec. 1 A; Sec. II. A;<br>Sec. VII. B 5, B 6, C.<br>**Case Management Standards & Certification Procedures**<br>Section IV. A.<br>**CFC Program Manual**<br>Sec. IV. 11 D. 8, E.<br>**Adult Family Care Training Materials**<br>Goal and General Policies;<br>Sec. 1. b-c; 2 b.<br>**Adult Family Care Participant Rights**<br>**Standards for Adult Day Services**<br>Sec. I. A, B<br>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.<br>• Case management standards support planning that promotes the least restrictive, most appropriate setting in accordance with needs and preferences.<br>• ERC settings accept Medicaid and non-Medicaid admissions and are not disability specific.<br>• 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.<br>• Employment and access to competitive work is not a goal area within Choices for Care.<br>• Participants' Rights include individuality and community participation.<br>• 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.<br>• Adult Day services are designed to assist adults to remain as active in their communities as possible and ensure optimal functioning. | Alignment | Partial<br>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**<br>Sec. I. A; Sec. II. A, D;<br>Sec. VII. A 1 (f); A 2 (c) and (g); C.<br>**CFC Program Manual** | • CFC regulations provide that persons receive information on all options available within the Choices for Care Program.<br>• 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.<br>Section IV. 11, D 8.<br>**Case Management Standards & Certification Procedures**<br>Section IV. C.<br>**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.<br>• 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.<br>• 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**<br>Sec. XIII. B 1-7<br>**Adult Family Care Participants' Rights Agreement**<br>**Residential Care Homes Licensing Regulations**<br>Sec. 5.14<br>Sec. 6<br>**Assisted Living Licensing Regulations**<br>Sec. I. 1.1, Sec. VI. 6.7<br>**Standards for Adult Day Services**<br>Sec. I. A<br>Sec. VIII. C<br>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.<br>• 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 | | |
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| **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**<br>Sec. VII. B 5<br>**CFC Program Manual**<br>Sec. III. C 7.<br>Sec. IV. 11 D 8, E<br>**Case Management Standards & Certification Procedures**<br>Sec. II.<br>Sec. IV. B 1-3<br>**Residential Care Home Licensing Regulations**<br>Sec. 1.1; 5.5(b); 5.10 (e) (2)<br>Sec. VI.<br>**Assisted Living Licensing Regulations**<br>Sec I. 1.1<br>Sec VI. 6.7; 6.9(a); 8.1<br>**Adult Family Care Training Materials**<br>Goal and General Policies<br>At a Glance 1.b-c; 2.b<br>**Adult Family Care Participant Rights Standards for Adult Day Services**<br>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.<br>• Adult Family Care is expected to include community access, leisure time activity, and participation in community functions.<br>• 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.<br>• 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.<br>• Case managers are required to assist persons to remain as independent as possible in accordance with their wishes.<br>• 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.<br>• 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.<br>• 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 | | |
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| **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<br>Sec. XII. D | • Assisted Living Licensing regulations require a daily program of activity, including periodic access to community resources.<br>• Participants have the right to refuse any services or activities offered.<br>• 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**<br>Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C<br>**Case Management Standards & Certification Procedures**<br>Sec. IV. A, B, C<br>**CFC Program Manual**<br>Sec. III. C 7<br>Sec. IV. 11, D 8, E<br>**Adult Family Care Training Materials**<br>Goal and General Policies;<br>Sec. 1. b-c, 2. b<br>**Adult Family Care Participant Rights**<br>**Adult Family Care Service Plan** (Consent Statement)<br>**Standards for Adult Day** | • All Participants choose where to receive their long-term services and supports.<br>• 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.<br>• Participants who choose ERC in a Residential Care Home or Assisted Living Residence receive an all-inclusive package of services that includes case management.<br>• Participants residing in ERC settings may arrange and pay for additional services and supports.<br>• Participants may self-manage their own care through the Flexible Choices program. | Alignment | Alignment | Alignment |

| HCBS Settings Requirements: VT Policy Assessment | | | Policy Alignment | | |
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| **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**<br>Sec. I. A, B<br>Sec. X. A, B<br>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.<br><br>(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**<br>Sec. IV. 11 D.11<br>**Residential Care Home Licensing Regulations**<br>Sec. 4.3 (b), (d), (e)<br>Sec. 5.2 (a-d), 5.3 (a), (e-h)<br>Sec. 6.14<br>**Assisted Living Licensing Regulations**<br>Sec. 3.3, 3.4<br>Sec. 6.5, 6.12, 6.14<br>Sec. 7.1<br>Sec. 8.2<br>Sec. 9<br>**Adult Family Care Participant Rights**<br>Sec. 2, 13, 14 | • Adult Family Care settings require a live-in agreement that includes room and board arrangements and termination agreements.<br>• 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).<br>• 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).<br>• Written plans of care, reviewed at least annually, are also required to address participant services, supports, and goals. | Alignment | Alignment | N/A<br>(not a residential service) |

| HCBS Settings Requirements: VT Policy Assessment | | | Policy Alignment | | |
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| **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**<br>**Residential Care Home Licensing Regulations**<br>Sec. X. 9.2(e-g)<br>**Assisted Living Licensing Regulations**<br>Sec. II. 3.2<br>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.<br>• 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).<br>• 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<br>(not a residential service) |
| 8. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors | **CFC Program Manual**<br>Sec. IV. 11 E.<br>**Residential Care Home Licensing Regulations**<br>Sec. IX<br>**Assisted Living Licensing Regulations**<br>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.<br>• Adult Family Care materials do not specify lockable door standards but do require that written agreements and care plans outline all shared living arrangements.<br>• Residential Care Level III licensing standards do not specify lockable units.<br>• Assisted Living Residence licensing standards require lockable units. | Partial<br>Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences and needs | Partial<br>Residential Care Home Licensing Regulations are silent regarding lockable door requirements | N/A<br>(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**<br>Sec. IV. 11 E.<br>**Residential Care Home Licensing Regulations**<br>Sec. IX<br>**Assisted Living Licensing Regulations**<br>Sec. 11.1 | • Adult Family Care Guidelines only authorize 1- or 2-person homes based on person's choice.<br>• Residential Care Level III licensing standards do not specify how semi-private placements are made.<br>• 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<br>Residential Care Home Licensing regulations are silent regarding how roommates are assigned in semi-private situations | N/A<br>(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**<br>Sec. IV. 11 E.<br>**Residential Care Home Licensing Regulations**<br>Sec. IX<br>**Assisted Living Licensing Regulations**<br>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.<br>• Residential Care Level III licensing standards do not specify standards for room décor.<br>• Assisted Living Residence licensing standards are considered private lease units but do not specify standards for room décor. | Partial<br>Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences | Silent | N/A<br>(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**<br>Sec. 7.1 (c)(4)<br>**Assisted Living Licensing Regulations**<br>Sec. X. 10.1<br>Sec. XI. 11.2 (b), 11.5 (a)<br>**CFC Program Manual**<br>Sec. IV. 11 E. 5<br>Standards for Adult Day<br>Sec. I. A, B<br>Sec. X. A, B, F5,<br>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.<br>• Residential Care Level III licensing standards provide for alternative meals on request but do not specify 24/7 access to food.<br>• 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.<br>• 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.<br>• Adult Day Services are structured daytime programs; however, the person has the right to refuse participation in daily activities and | Partial<br>Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences | Partial<br>Residential Care Homes offer meal plans and are required make options available as requested by participants.<br>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<br>• 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.<br>• Assisted Living Residences are considered private units.<br>• Standards for Adult Day Service are silent on visitors | Partial<br>Service plans and live-in agreements would benefit from more specific guidance regarding participant preferences | Partial<br>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**<br>Sec. XI<br>**Standards for Adult Day Services**<br>Sec. I. A, B<br>Sec. X. B 8, G<br>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.<br>• 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.<br>• 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.<br>• Standards for Adult Day services require participant assessment and written service plans. | Alignment<br>Documentation requirements could be stronger | Alignment<br>Documentation requirements could be stronger | Alignment<br>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**<br>Sec. XI<br>**Residential Care Home Licensing Regulations**<br>Sec. III<br>Sec. V. 5.3<br>**Assisted Living Residences Licensing Regulations**<br>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**<br>Sec. XI<br>**Residential Care Home Licensing Regulations**<br>Sec. III<br>Sec. V. 5.3<br>**Assisted Living Residences Licensing Regulations**<br>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.<br>• 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.<br>• 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.<br>• CFC participants choose where to receive services and the settings in which they live commensurate with their needs and level-of-care determination.<br>• Case management standards support planning that promotes the least restrictive, most appropriate setting in accordance with needs and preferences.<br>• Assisted Living Residences assume a person will age in place and only allow for termination of services in specific circumstances. | Alignment<br>Documentation requirements could be stronger | Alignment<br>Documentation requirements could be stronger | Alignment<br>Documentation requirements could be stronger |
| (d) Include a clear description of the condition that is directly proportionate to the specific assessed need | **CFC Regulations**<br>Sec. IV. B 1, B 2<br>Sec. VII. B 5, B 6<br>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.<br>• Changes are by participant choice or as medically directed.<br>• 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.<br>• 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**<br>Sec. XI. D | • Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders.<br>• 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**<br>Sec. XI | • Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders.<br>• 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**<br>Sec. XI | • Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders.<br>• Adult Family Care Agreements include a consent.<br>• Variance requests do not specify informed consent; however, they are permissive of DAIL's requiring any additional detail needed to address the request.<br>• Adult Day Standards require informed consent in planning processes. | Partial<br>Documentation requirements could be stronger | Partial<br>Documentation requirements could be stronger | Alignment |
| (h) Include an assurance that interventions and supports will cause no harm to the individual | **CFC Regulations**<br>Sec. XI<br>**Residential Care Home Licensing Regulations**<br>Sec. III, Sec. V. 5.3<br>**Assisted Living Residences Licensing Regulations**<br>Sec. 4, 6.5 | • Changes are by participant choice or as medically directed; medically directed changes are reviewed based on physician orders.<br>• 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<br>Documentation requirements could be stronger | Alignment<br>Documentation requirements could be stronger | Alignment<br>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 | | |
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| **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**<br>Sec. VII. B 5<br>**CFC Program Manual**<br>Sec. III. C 7<br>**Case Management Standards & Certification Procedures**<br>Sec. IV. B, C, G, H, I<br>**Case Management Action Plan Guide**<br>**Standards for Adult Day Services**<br>Sec. I. A, B<br>Sec. X. A, B<br>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.<br>• 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**<br>Sec. I. A; Sec. II. A, D;<br>Sec. VII. A 1 (f); B 5, B 6, C.<br>**Case Management Standards & Certification Procedures**<br>Sec. IV. A, B, C<br>**CFC Program Manual**<br>Sec. III. C 7<br>Section IV. 10, 11 E 1<br>**Adult Family Care Participant Rights**<br>**Adult Family Care Service Plan** (Consent Statement | • CFC regulations provide that persons receive information on all options available within the Choices for Care Program.<br>• DAIL Clinical Care staff is required to discuss all available long-term care options as part of the application process.<br>• 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 | | |
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| **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**<br>Sec. IV. F, I<br>**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.<br>• Case Management Action Plan Guide does not address location. | Partial<br>Guidance discusses participant direction but does not specify time and location arrangements | Partial<br>Guidance discusses participant direction but does not specify time and location arrangements | Partial<br>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**<br>Sec. IV. A, B, C, G, I<br>**Case Management Action Plan Guide**<br>**AHS Limited English Proficiency Policy**<br>**Standards for Adult Day Services**<br>Sec. I A, B<br>Sec. X A, B<br>Sec. XI D4<br>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.<br>• Case Management Action Guide calls for plans to be written in 'Plain English' using terms and language that the participant can understand.<br>• 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**<br>Sec. II. F; Sec. XII; Sec. XIII. B 2-4, C 3-5<br>**CFC Program Manual**<br>Sec. III. C 5, C 6, C 16, C 18<br>**Case Management Standards & Certification Procedures**<br>Sec. III. B, K | • CFC regulations call for a process for handling participant feedback, complaints, and disagreements.<br>• 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.<br>• The CFC grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration. | Alignment | Alignment<br>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<br>**Standards for Adult Day Services**<br>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**<br>Sec. XII<br>Sec. XIII. B 2, B 3, B 4, B 5<br>**CFC Program Manual**<br>Sec. III. C 5, C 6, C 16, C 18<br>**Case Management Standards & Certification Procedures**<br>Sec. III. B, K<br>Sec. IV. L, M<br>**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.<br>• VT Statute requires a Long-Term Care Ombudsman program.<br>• DAIL has established Aging and Disability Resource Centers statewide for information and referral, options counseling, and assistance with understanding grievance and appeal rights.<br>• 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.<br>• 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.<br>• 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<br>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.<br>• 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.<br>• The CFC grievance and appeal process requires adherence to Medicaid Managed Care grievance and appeal rules under the GC demonstration.<br>• 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**<br>Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f); B 5, B 6, C.<br>**Case Management Standards & Certification Procedures**<br>Section IV. A, C<br>**CFC Program Manual**<br>Sec. III. C 7<br>Sec. IV. 11, E<br>**Adult Family Care Training Materials**<br>Goal and General Policies; Sec. 1. b-c; 2 b<br>**Adult Family Care Participant Rights**<br>**Adult Family Care Service** | • All Participants choose where to receive their long-term services and supports.<br>• DAIL Clinical Care Coordinators are responsible for ensuring that recipients have made informed choices regarding where and from whom they receive services.<br>• 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.<br>• 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**<br>Sec. IV. B, F, G, I<br>**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.<br>• 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.<br>• 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.<br>• Adult Family Care Service Plan includes consent and signature line noting that the participant was informed of all options. | Alignment | Alignment<br>Documentation could be strengthened | N/A |
| 10. Reflect that the setting in which the individual resides is chosen by the individual. | **CFC Regulations**<br>Sec. I. A; Sec. II. A, D; Sec. VII. A 1 (f), A 2 (b), (c), (g); C<br>**CFC Program Manual**<br>Sec. III. C 7<br>Sec. IV. 11, D 8, E<br>**Case Management Standards Certification Procedures**<br>Sec. IV. C<br>**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.<br>• 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<br>Documentation could be strengthened | Partial<br>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.<br>• 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<br>**CFC Program Manual** Sec. IV. 11 D 8<br>**Case Management Standards & Certification Procedures** Sec. IV. B, G, H, I, J, K<br>**Case Management Action Plan**<br>**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<br>**CFC Program Manual** Sec. IV. 11 D 8<br>**Adult Family Care Training Materials**<br>**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**<br>**Standards for Adult Day Services**<br>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**<br>**Standards for Adult Day Services**<br>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.<br>• 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**<br>Sec. IV. B 3, K 9<br>**Assisted Living Licensing Regulations**<br>Sec. IX. Negotiated Risk<br>**Standards for Adult Day Services**<br>Sec. IV. A<br>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.<br>• 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**<br><br>**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.<br>• 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**<br>**CFC Program Manual**<br>Sec. IV. 10 | • Case Management Action Plan calls for all persons responsible (formal and informal supports) to be noted in the plan.<br>• 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**<br>Sec. VII. B 6<br>**CFC Program Manual**<br>Sec. III. C 4, C 8, C 17<br>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**<br>Sec. IV. B, F, G, I<br>**Case Management Action Guide**<br>**Residential Care Home Licensing Regulations**<br>Sec. 5.7, 5.9(c)<br>**Assisted Living Residence Licensing Regulations**<br>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.<br>• 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 2d - DS HCBS Action Items

# Developmental Disabilities Services Division HCBS Work Plan

| **Regulation: Settings Requirements**<br><br>**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 –<br><br>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>:<br><br>Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.<br><br><u>Case Management should not be influenced by a conflict of interest</u>:<br><br>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<br><br>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 3a - DLTSS-ACO Quality Measures Y1 Sub-Analysis 9-2016

# Vermont Medicaid Shared Savings Program (VMSSP) Quality Measures: Year 1 DLTSS Sub-Analysis

VHCIP DLTSS Work Group Meeting

October 6, 2016

Vermont Health Care Innovation Project

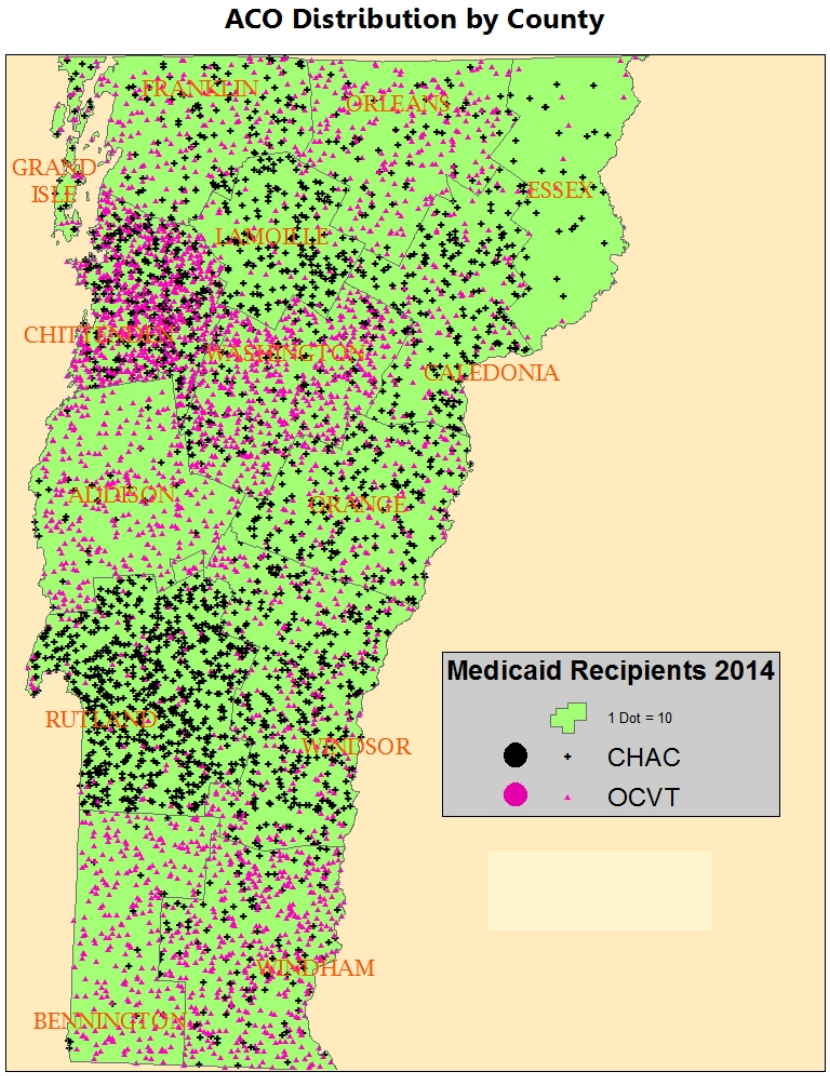
# Sub-Analysis Objectives

- To measure the quality of care of Medicaid members who receive disability and/or long term services and supports and who are also attributed to an ACO in the Vermont Medicaid Shared Savings Program (VMSSP)
- To work with the State's independent analytics contractor, The Lewin Group, to calculate performance measures consistently with overall VMSSP quality results

# VMSSP: Beneficiary Attribution

- Eligible populations:
  - General Adult
  - General Child
  - Aged, Blind or Disabled Adult and Child
- Excluded populations:
  - Individuals dually eligible for Medicare and Medicaid
  - Individuals with third party liability coverage
  - Individuals with coverage through commercial insurers
  - Individuals who are enrolled in Medicaid but receive a limited benefits package

# VMSSP Participation




- Two ACOs have contracts with DVHA to participate:
  - OneCare Vermont
  - Community Health Accountable Care (CHAC)
- In first program year (2014):
  - **37,929** Medicaid beneficiaries attributed to OneCare
  - **26,587** Medicaid beneficiaries attributed to CHAC

# Defining the DLTSS Sub-Population

- Used the same definition as the DLTSS Medicaid Expenditure Analysis
- Start with all Medicaid members attributed to an ACO during Year 1 (2014) of the VMSSP
- Exclude members who did not have claims (identified by Category of Service) for any of the following services in the program year:

- Choices for Care – Assistive Community Care
- Choices for Care – HCBS
- Choices for Care – Nursing Home
- Community Rehabilitation and Treatment
- Day Treatment/Private Non-Medical Inst.
- Department for Children and Families
- Developmental Services – HCBS
- Developmental Services – ICF/ID
- HCBS SED Children and Adolescents
- Mental Health Facility
- Personal Care Services
- School Health – Department of Health
- School Health – School-Based Health Svcs.
- School Health – Success Beyond Six
- Substance Abuse Treatment
- Targeted Case Management
- Traumatic Brain Injury Program

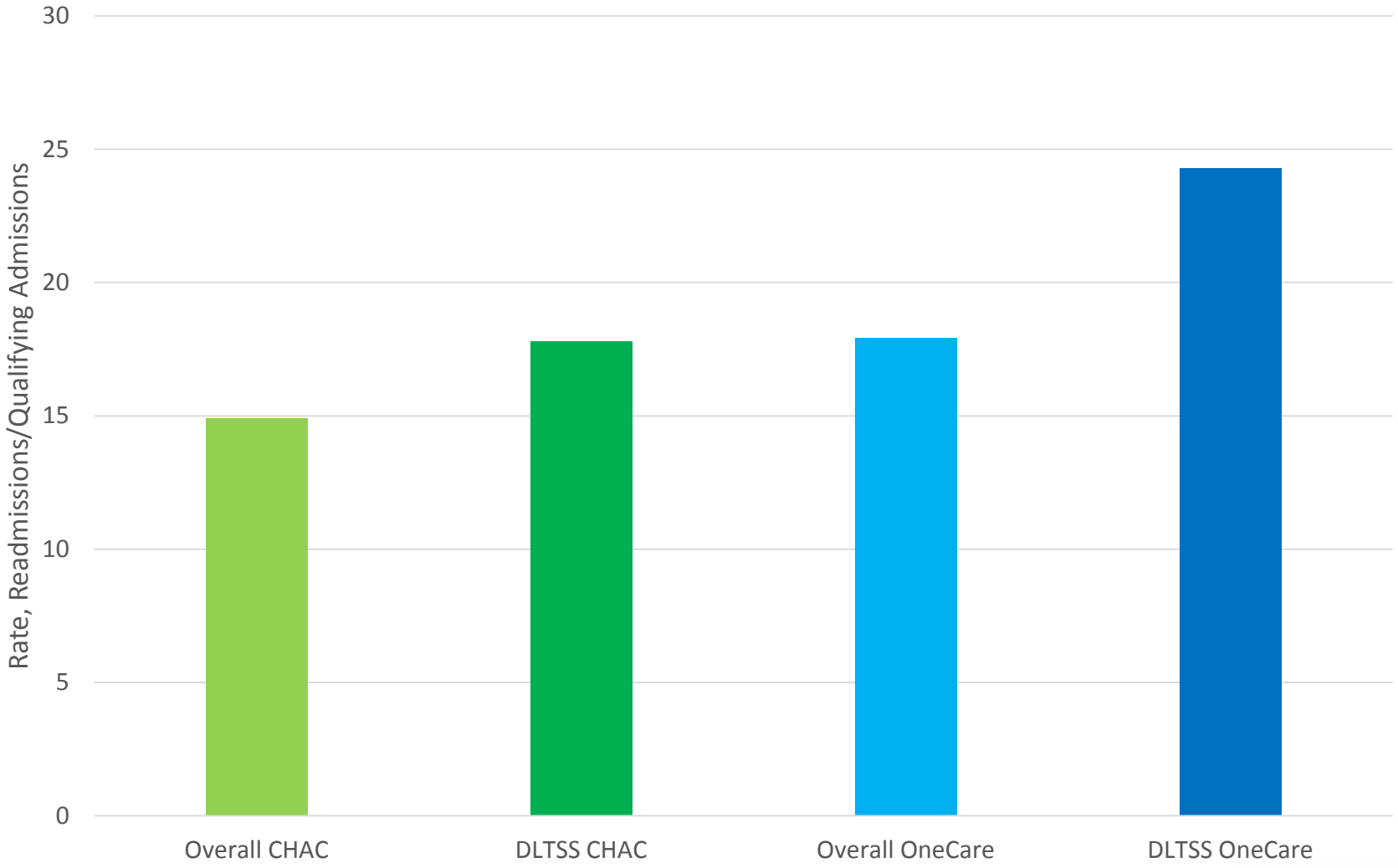
# Quantifying the DLTSS Sub-Population

| 2014 ATTRIBUTION BY MEDICAID CATEGORIES OF SERVICE | CHAC | OneCare | Eligible for attribution (unattributed) | TOTAL |
|---|---|---|---|---|
| Choices for Care - Assistive Community Care | 16 | 6 | 19 | 41 |
| Choices for Care - HCBS | 33 | 42 | 40 | 115 |
| Choices for Care - Nursing Home | 7 | 8 | 3 | 18 |
| Community Rehabilitation and Treatment | 178 | 150 | 101 | 429 |
| Day Treatment/Private Non-Medical Inst | 28 | 34 | 22 | 84 |
| Department for Children and Families | 1022 | 1600 | 1391 | 4013 |
| Developmental Services - HCBS | 101 | 146 | 125 | 372 |
| HCBS SED Children and Adolescents | 4 | 14 | 17 | 35 |
| Mental Health Facility | 360 | 851 | 622 | 1833 |
| Personal Care Services | 187 | 372 | 437 | 996 |
| School Health - Department of Health | 14 | 37 | 32 | 83 |
| School Health - School-Based Health Svcs | 1231 | 2090 | 2272 | 5593 |
| School Health - Success Beyond Six | 733 | 1128 | 1161 | 3022 |
| Substance Abuse Treatment | 1206 | 1134 | 999 | 3339 |
| Targeted Case Management - Mental Health | 180 | 256 | 188 | 624 |
| Traumatic Brain Injury Program | 1 | 2 | 3 | 6 |
| **TOTAL** | **5301** | **7870** | **7432** | **20603** |

# Key Considerations

- Sub-analysis only possible for claims-based quality measures at this time (both Payment and Reporting)
- Not all measures are applicable across the full population
  - Some are specific to age groups
  - Some are specific to individuals with certain diagnoses
- Results not reported for any measures with <30 individuals in the denominator
- Results are not risk-adjusted
- Lower rates are better where indicated *
- National 50th percentile where indicated --------

# Core 1: ACO All-Cause Readmission*



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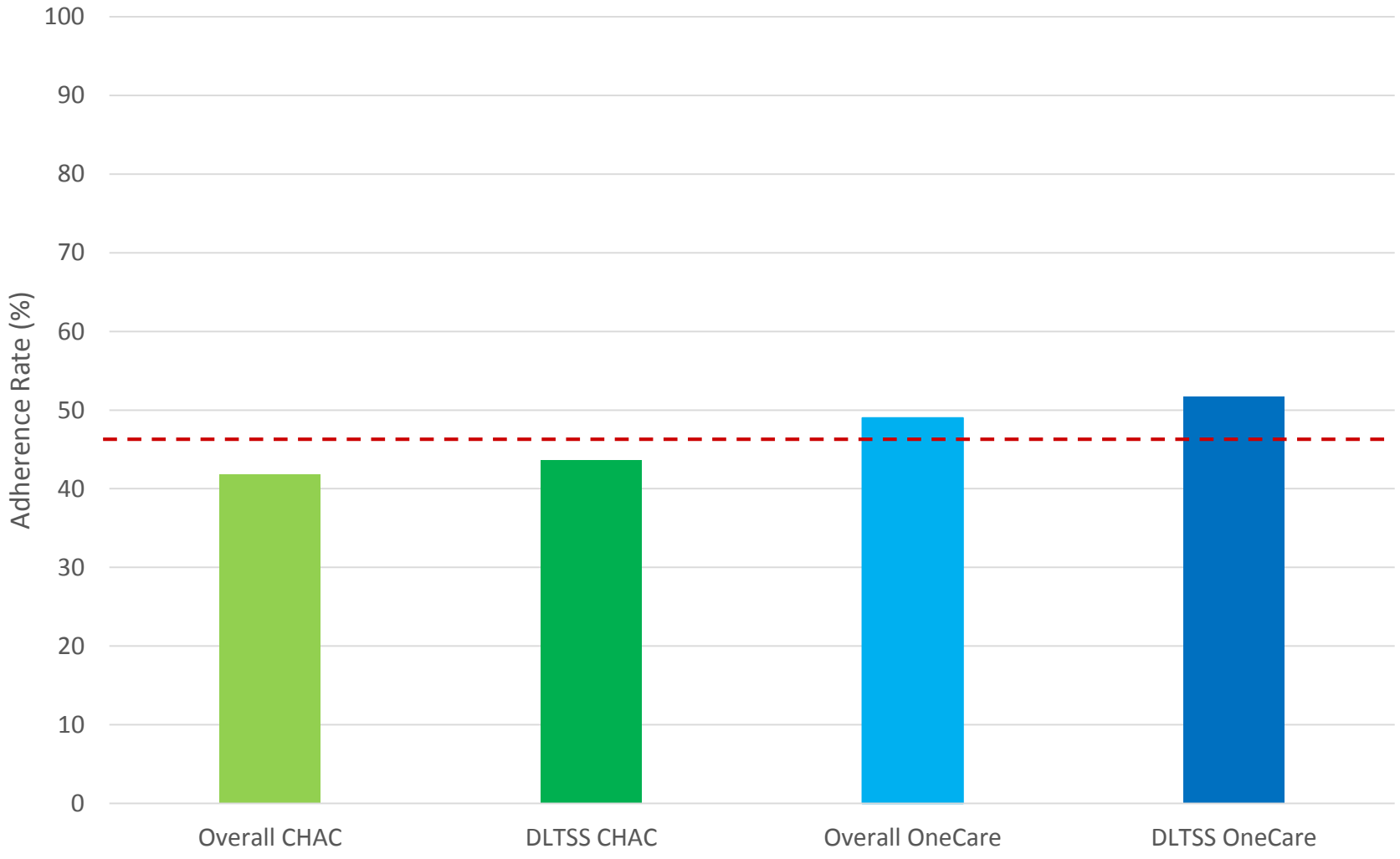
# Core 2: Adolescent Well-Care Visits



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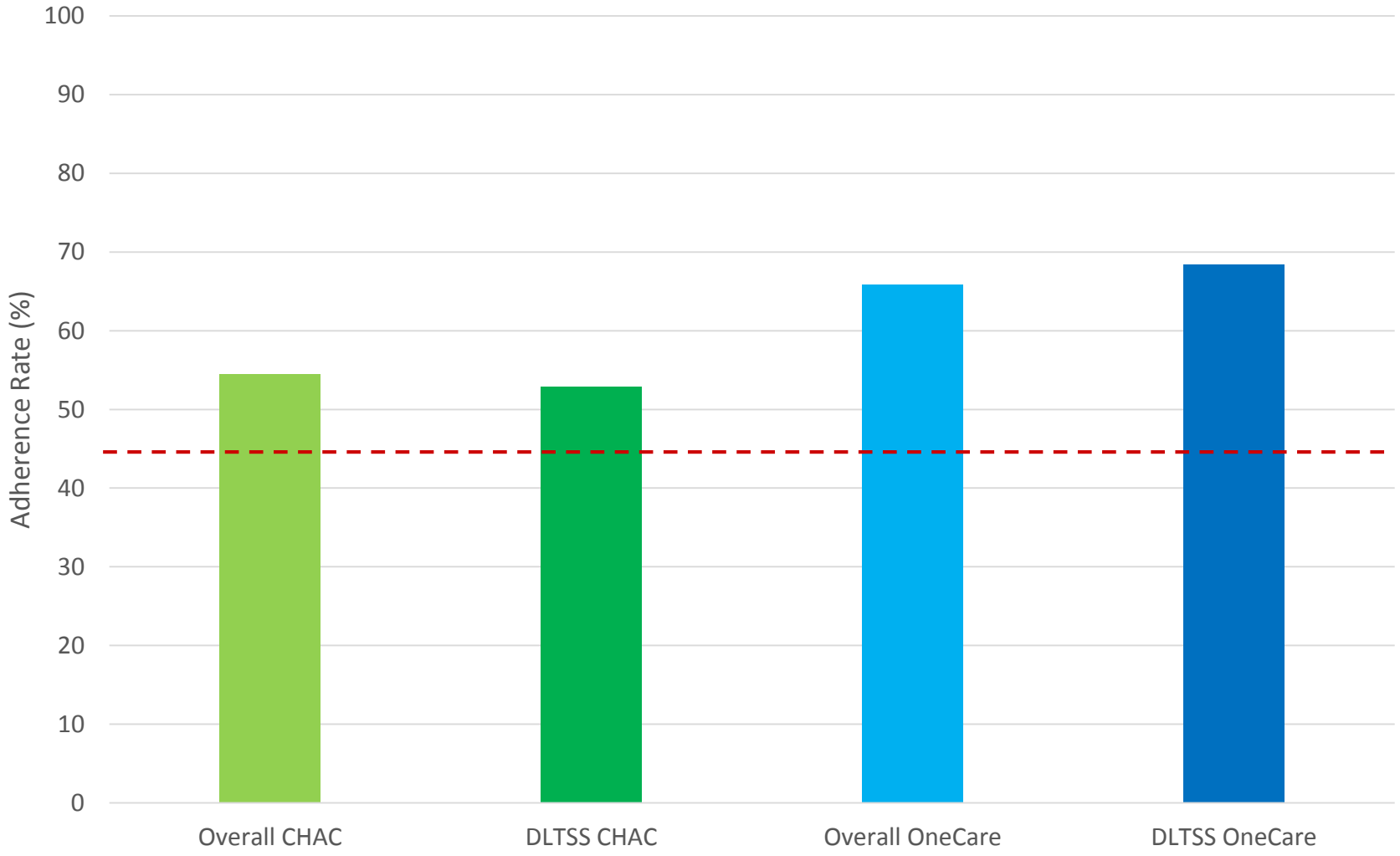
# Core 3: Cholesterol Management for Patients with Cardiovascular Conditions

- Results suppressed due to small sample size
- Fewer than 30 individuals in each ACO's DLTSS sub-population qualified for inclusion in this measure

# Core 4: Follow-Up after Hospitalization for Mental Illness



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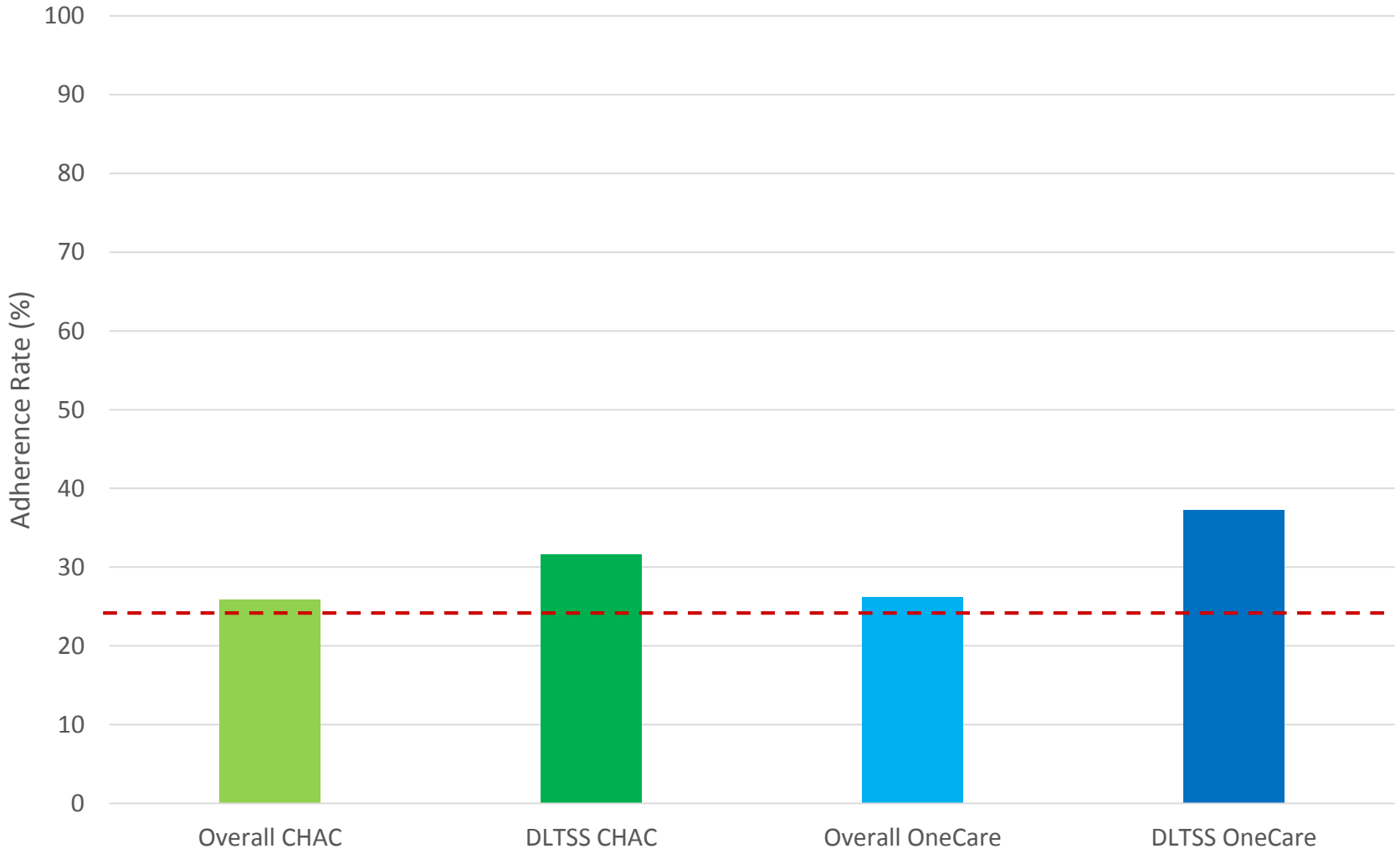
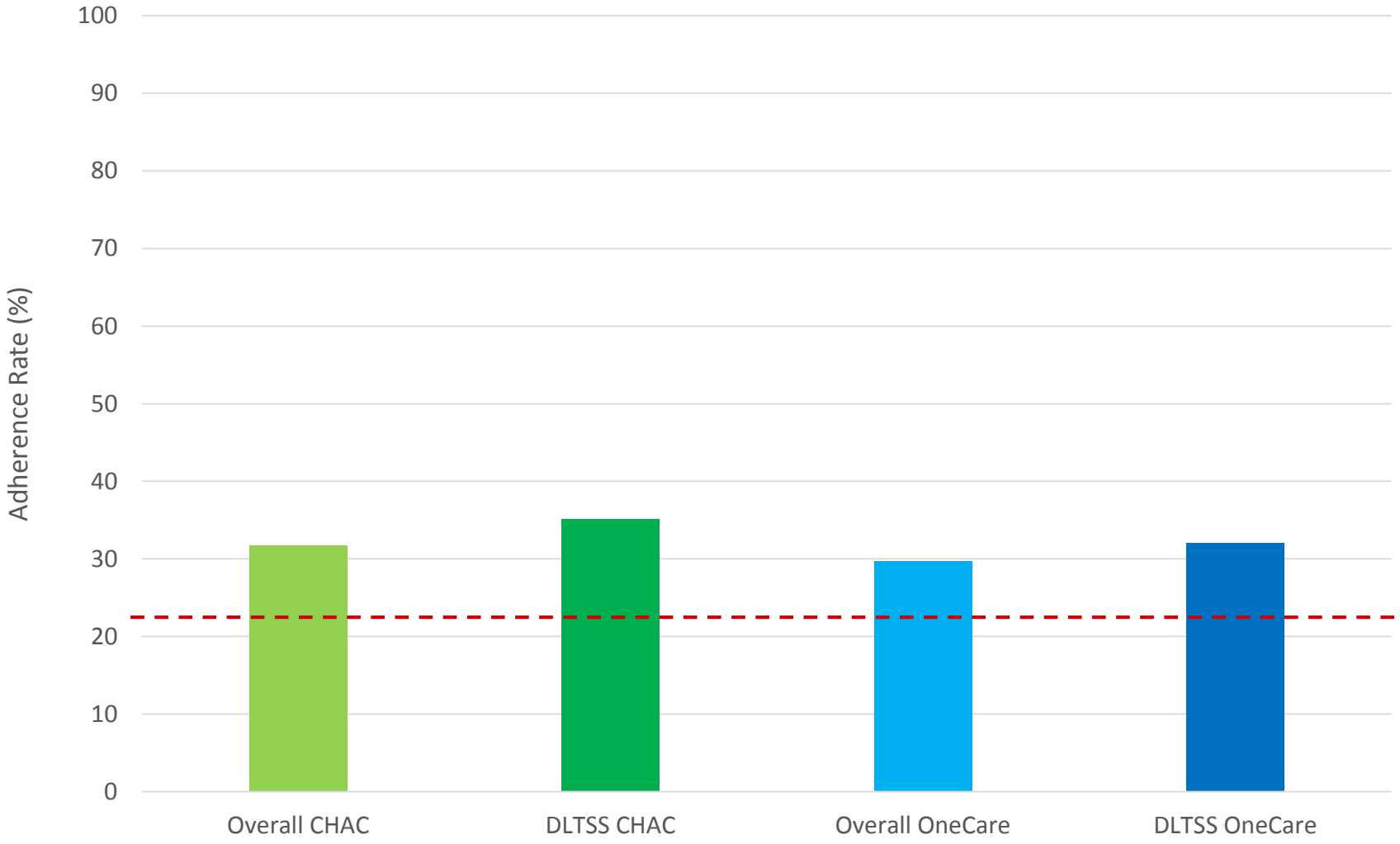
# Core 5: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Composite)



# Core 6: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



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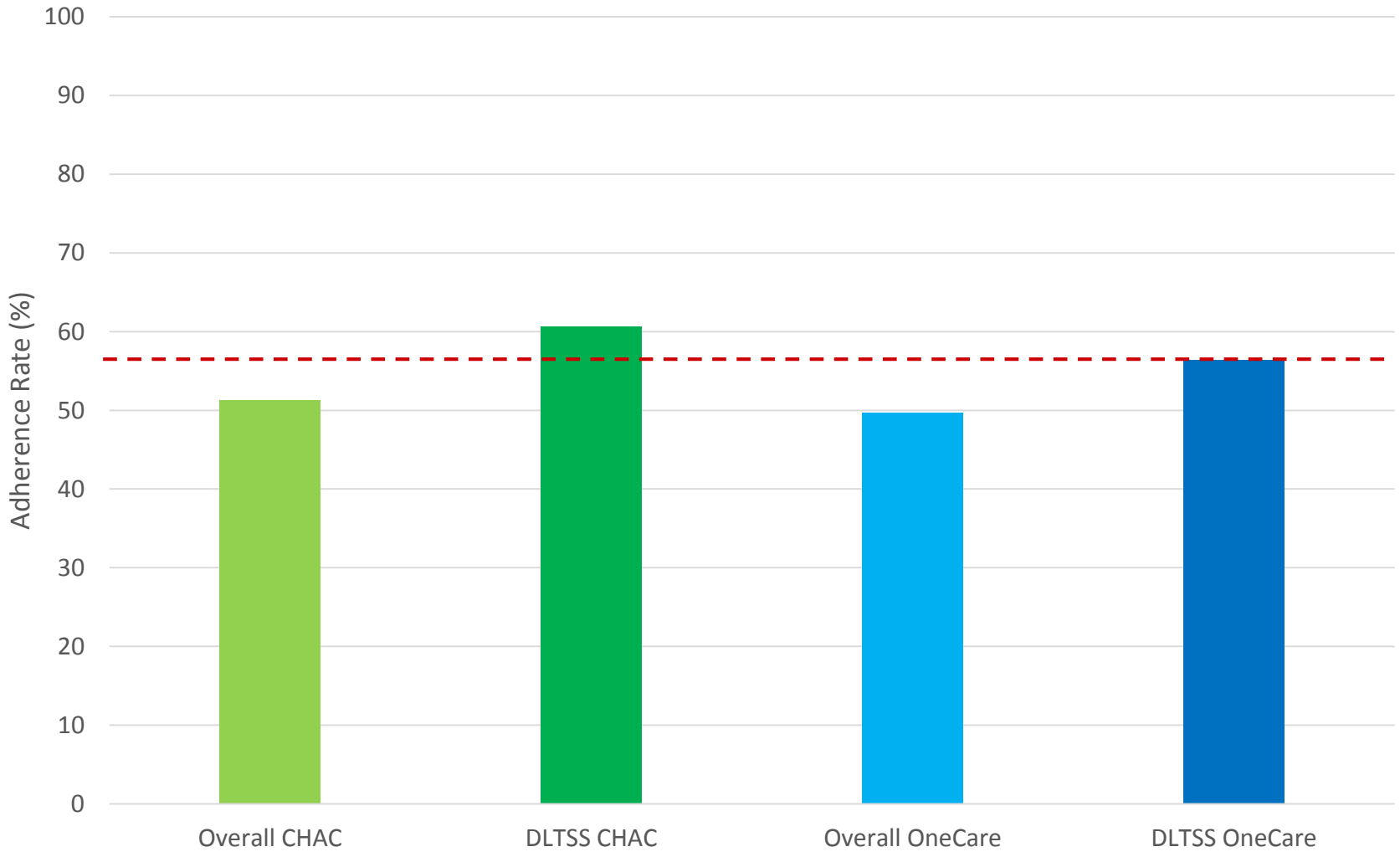
# Core 7: Chlamydia Screening



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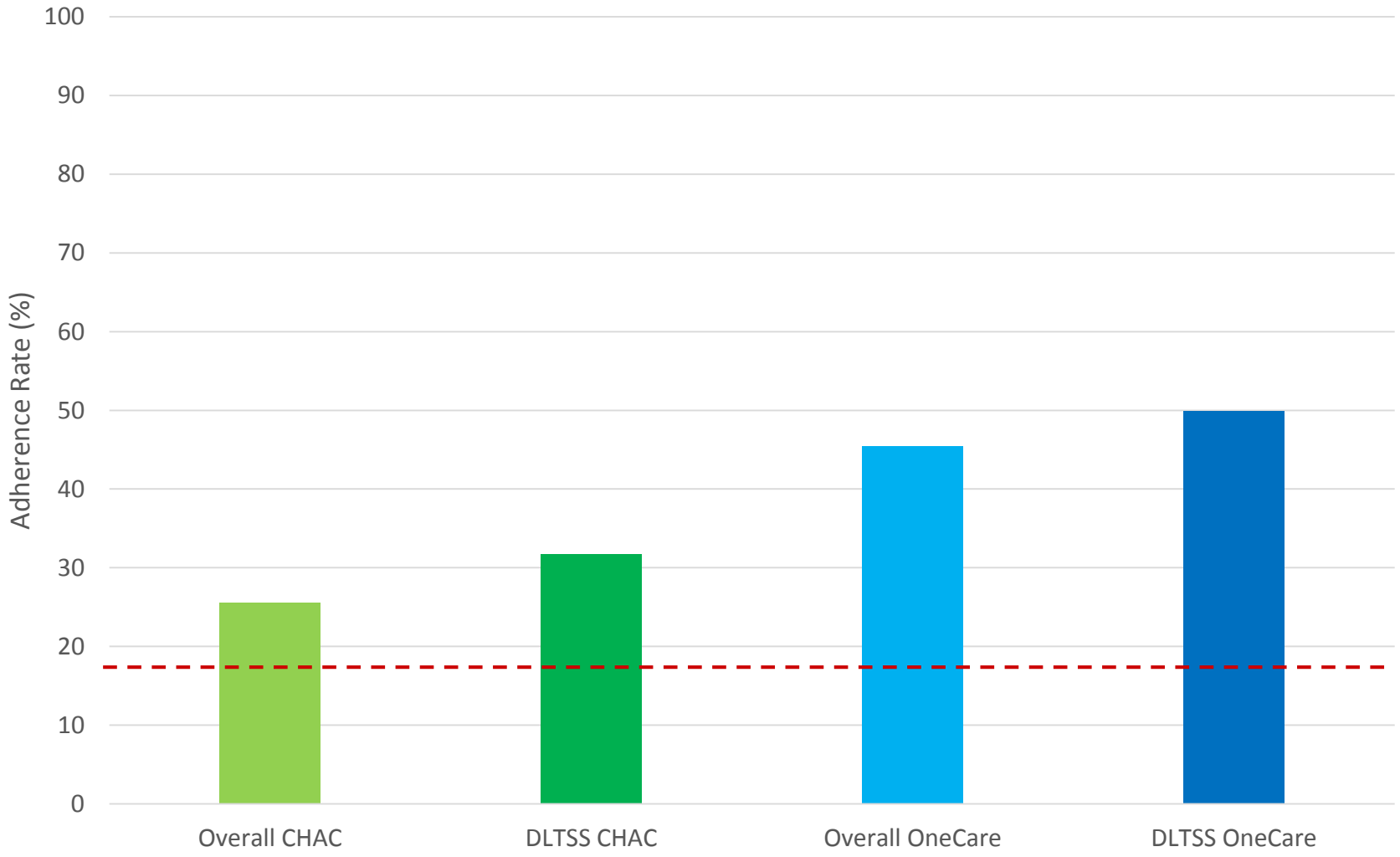
# Core 8: Developmental Screening in the First Three Years of Life



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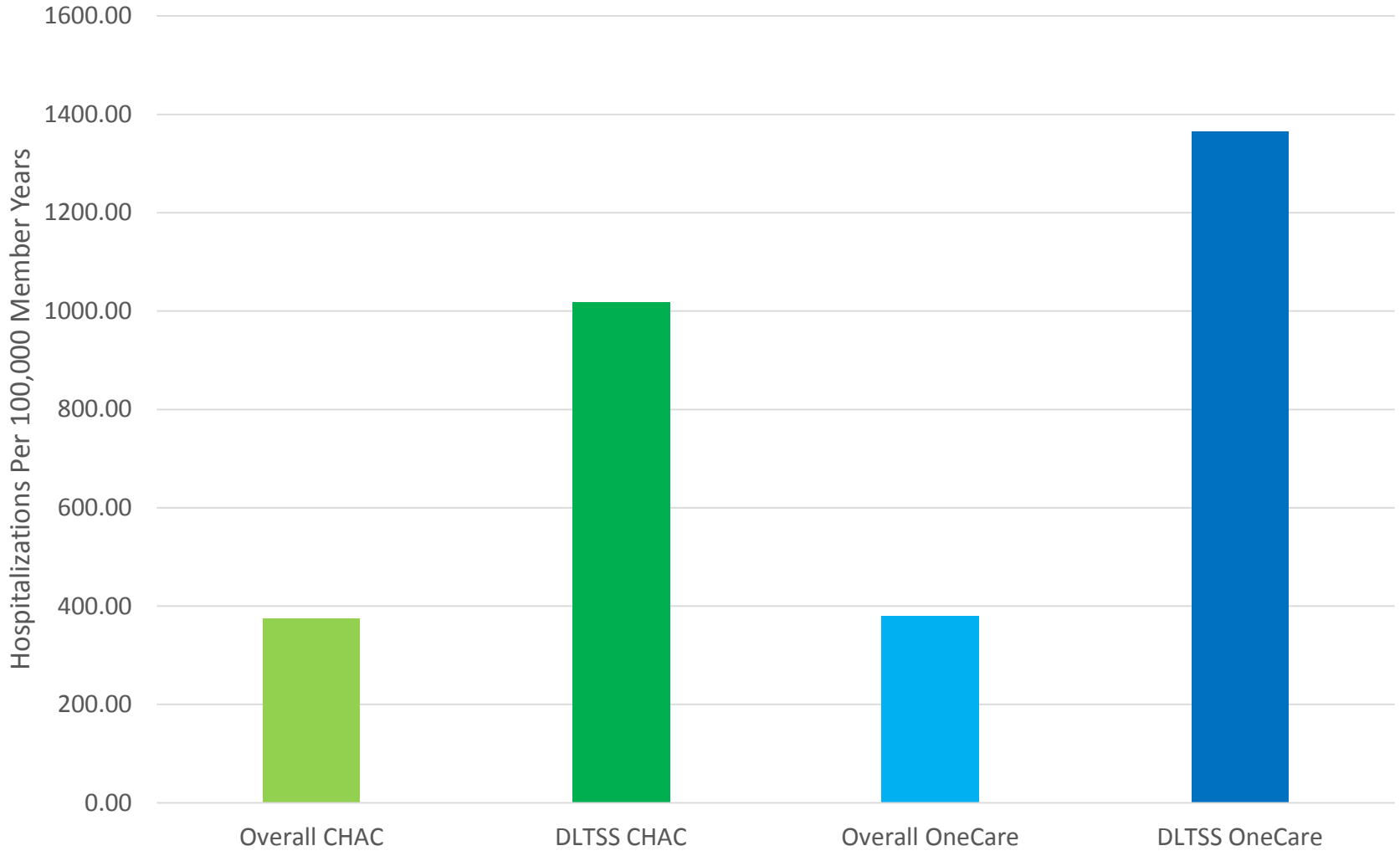
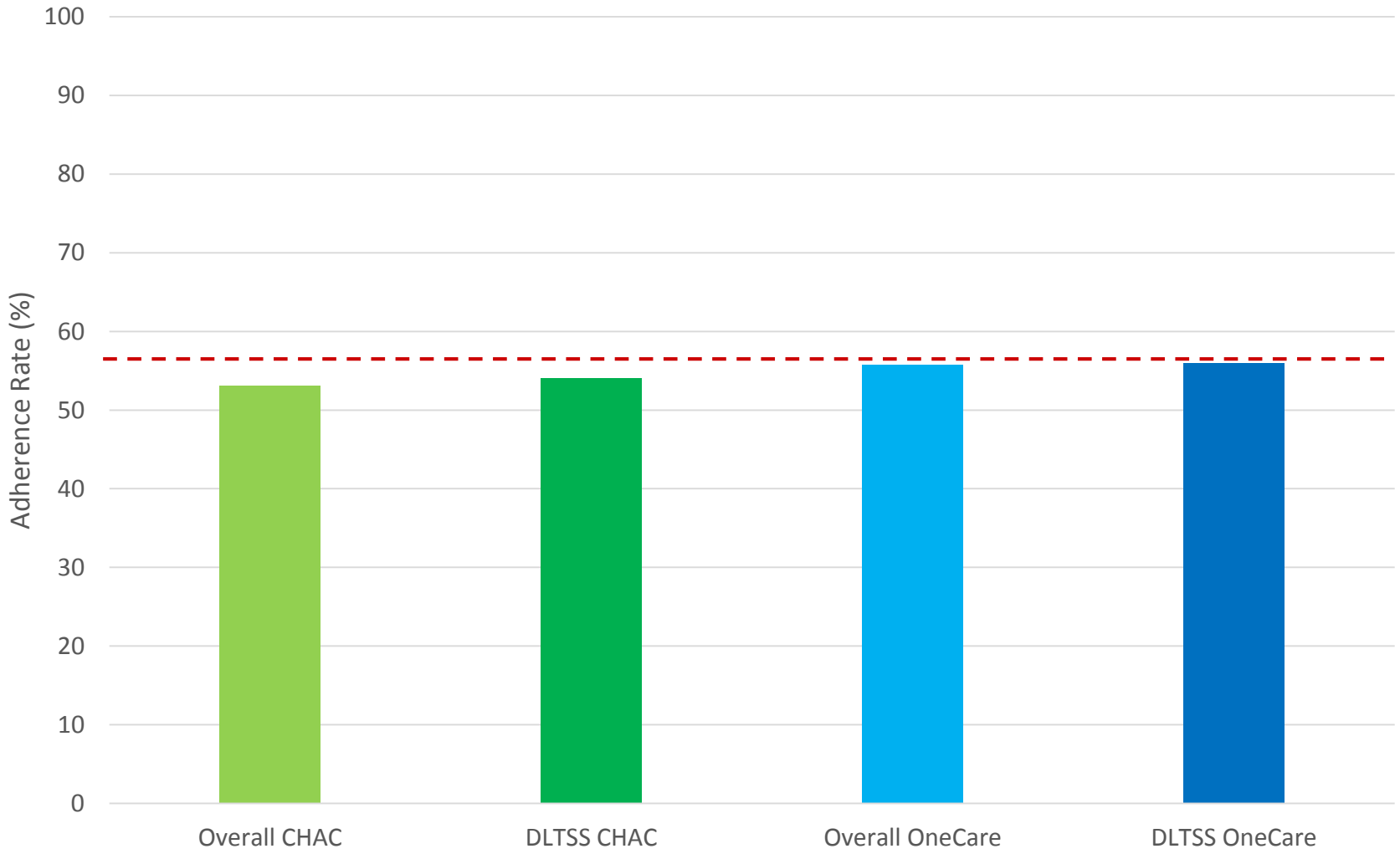
# Core 10: Hospitalizations for COPD or Asthma in Older Adults*



# Core 11: Breast Cancer Screening



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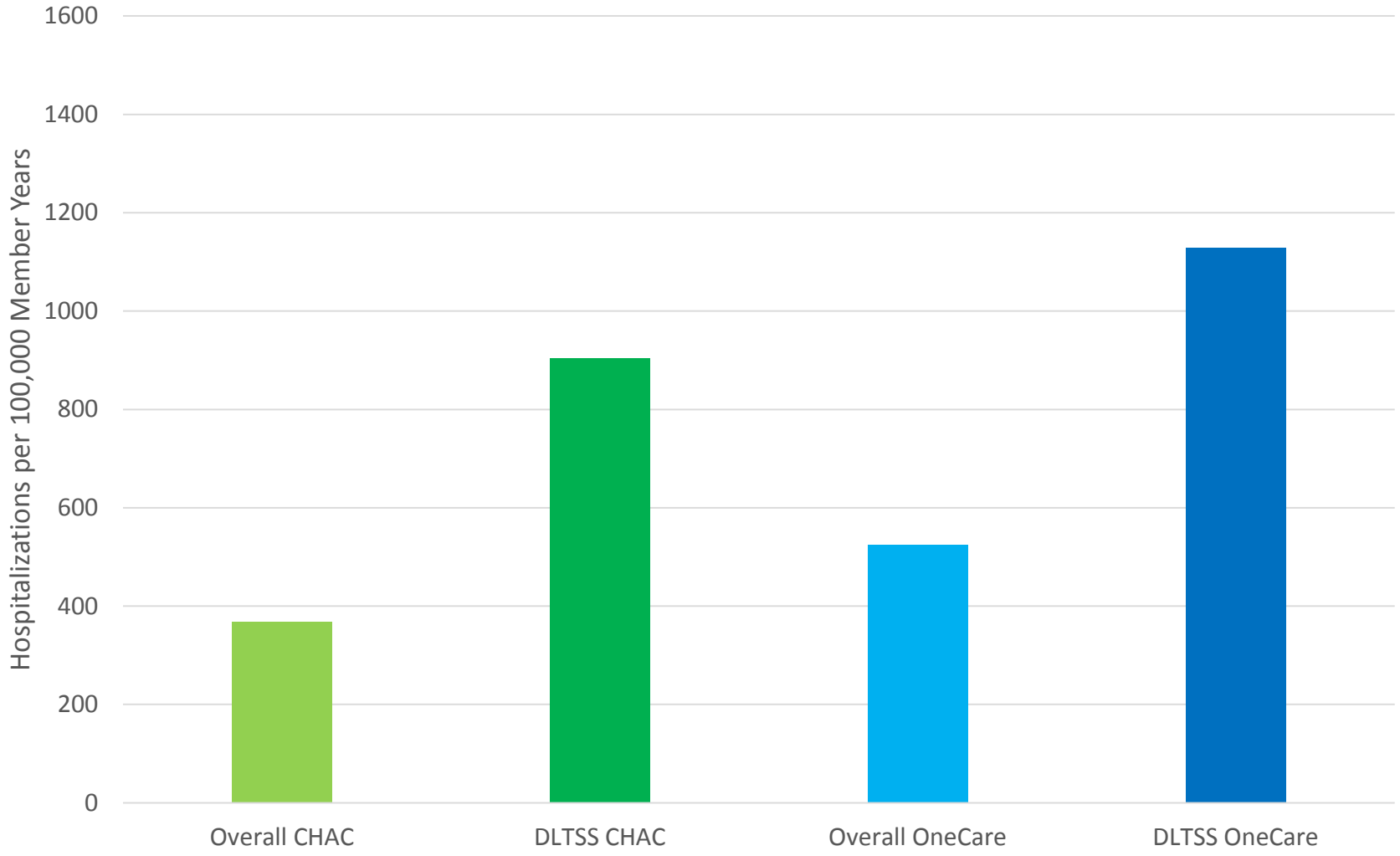
# Core 12: Hospitalizations for Ambulatory Care Sensitive Conditions*



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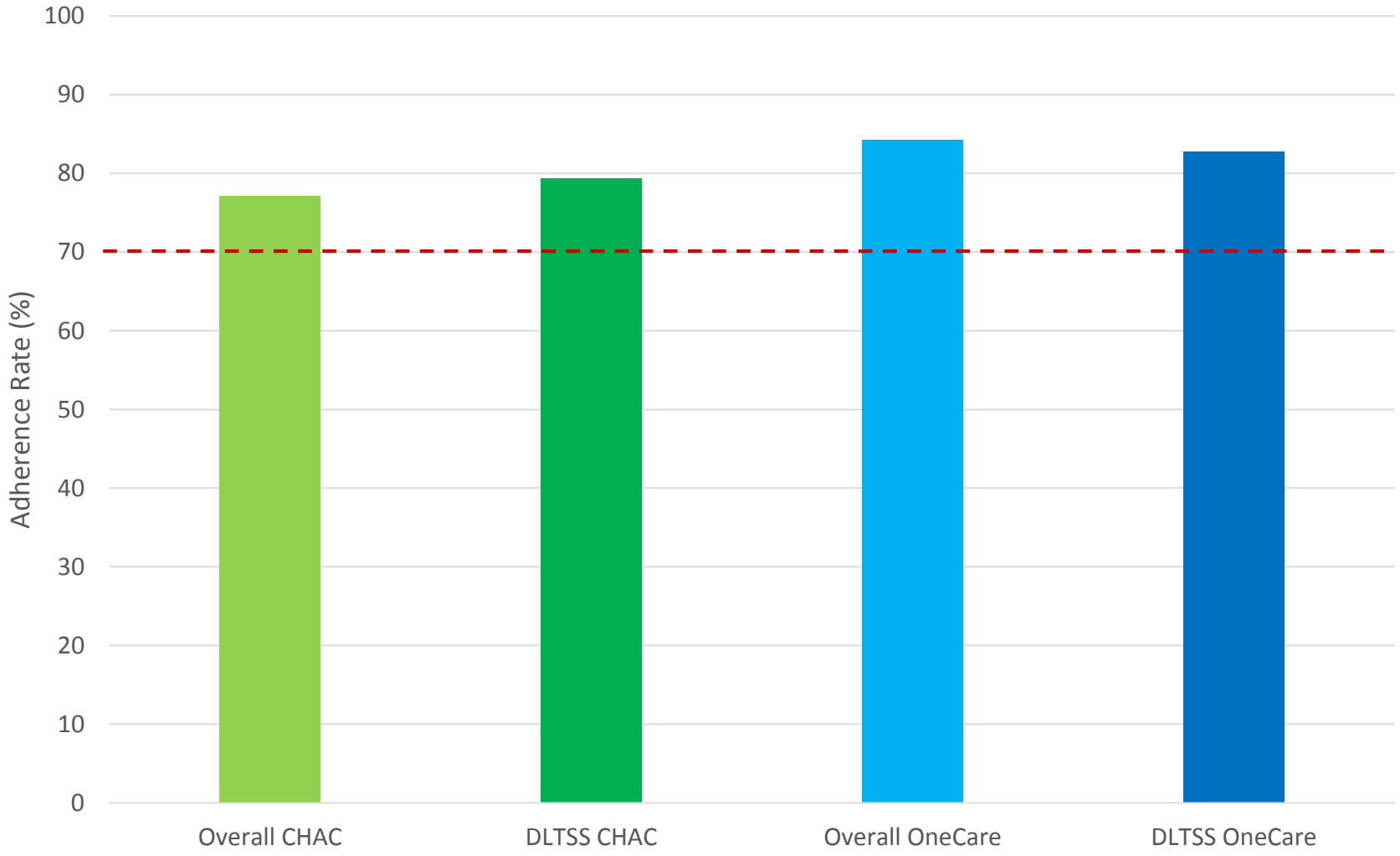
# Core 13: Appropriate Testing for Children with Pharyngitis



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# Summary

- For many of these measures, sub-population quality was similar to or better than that of the full ACO populations
- Individuals in the DLTSS sub-population experienced proportionally more admissions than the full ACO populations
- Opportunity to observe trends over time when more data is available

# Attachment 3b - DLTSS-ACO Quality Measures Y1 Sub-Analysis Spreadsheet 9-2016

| **Lewin notes the following items for the 04/15/16 - Year 1 (2014) Medicaid DLTSS Study:** |
| --- |
| This study captures the twelve requested payment and reporting measures in calendar year 2014 for the DLTSS<br>20,603 total member IDs were received from DVHA and reported on. The breakdown by attributed group was as follows:<br>CHAC - 5,301<br>OneCare - 7,870<br>Other (Eligible for Attribution but Unattributed) - 7,432 |
| Lewin reported on the 12 measures for each attributed group and for all three attributed groups combined (Overall) |
| Attributed group was identified from the data extract provided by DVHA. Lewin did not alter this attribution. |

## Medicaid DLTSS Study: Year 1 (2014) -- Payment Measures

*(Time period: 01/01/14 to 12/31/14)*

Use 11x17 paper when printing-suggest longitudinal splicing for paper viewing

| Measure and Detailed Description | Unit of Measurement | Rate | | | | Numerator/ Denominator | | | | 2013 HEDIS National Medicaid Benchmarks | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | CHAC Year 1 DLTSS | OneCare Year 1 DLTSS | Other Year 1 DLTSS | OVERALL Year 1 DLTSS | CHAC Year 1 DLTSS | OneCare Year 1 DLTSS | Other Year1 DLTSS | OVERALL Year 1 DLTSS | 25th | 50th | 75th | 90th |
| **CLAIMS-BASED PAYMENT MEASURES** | | | | | | | | | | | | | |
| #1*- **ACO All-Cause Readmission:** Patients 18 and over with an observed 30-day acute readmission compared to the predicted probability of an acute readmission | Observed Readmission Rate (%) | 17.16 | 24.30 | 18.85 | 20.43 | 35/204 | 61 / 251 | 36 / 191 | 132 / 646 | No Benchmark Available | | | |
| #2 - **Adolescent Well-Care Visits:** Patients 12-21 who had one comprehensive well-care visit with a PCP or an OB/GYN in the last 12 reported months | Adherence Rate (%) | 43.69 | 51.76 | 48.09 | 48.47 | 658/1,506 | 1,291 / 2,494 | 1,256 / 2,612 | 3205 / 6612 | 41.72 | 47.24 | 57.07 | 65.45 |
| #3 - **Cholesterol Management for Patients with Cardiovascular Conditions:** Patient(s) 18-75 years of age with a LDL cholesterol test during the reported period | Adherence Rate (%) | Supresssed, Denominator <30 | Supresssed, Denominator <30 | Supresssed, Denominator <30 | Supresssed, Denominator <30 | Supresssed, Denominator <30 | Supresssed, Denominator <30 | Supresssed, Denominator <30 | Supresssed, Denominator <30 | 78.33 | 81.45 | 84.91 | 87.84 |
| #4 - **Mental Illness, Follow-Up After Hospitalization:** Patients with a 7-day follow-up visit after hospitalization for a mental illness | Adherence Rate (%) | 52.87 | 68.42 | 65.13 | 62.29 | 83/157 | 117 / 171 | 99 / 152 | 299 / 480 | 30.91 | 43.95 | 54.64 | 68.79 |
| #5a **- Alcohol and Other Drug Dependence Treatment (IET) - Initiation:** Patient(s) with a new episode of alcohol and other drug dependence (AOD) who initiated treatment within 14 days of the diagnosis | Adherence Rate (%) | 44.03 | 51.72 | 52.05 | 49.12 | 317/720 | 360 / 696 | 330 / 634 | 1007 / 2050 | 36.03 | 39.13 | 43.11 | 48.24 |
| #5b **- Alcohol and Other Drug Dependence Treatment (IET) - Engagement:** Patient(s) with a new episode of alcohol and other drug dependence (AOD) who initiated treatment and had two or more follow-up visits within 30 days of the initiation visit (i.e. engaged in AOD treatment) | Adherence Rate (%) | 19.17 | 22.84 | 26.97 | 22.83 | 138/720 | 159 / 696 | 171 / 634 | 468 / 2050 | 5.14 | 10.37 | 16.17 | 19.84 |
| #5c - **Alcohol and Other Drug Dependence Treatment (IET) - Composite:** Composite measure of initiation and engagement of alcohol and other drug dependence treatment | Adherence Rate (%) | 31.60 | 37.28 | 39.51 | 35.98 | 455/1,440 | 519 / 1,392 | 501 / 1,268 | 1475 / 4100 | 20.59 | 24.75 | 29.64 | 34.04 |
| #6 - **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** Patients with a diagnosis of acute bronchitis who did not have a prescription for an antibiotic on or three days after the initiating visit | Adherence Rate (%) | 35.19 | 32.05 | 35.71 | 34.04 | 19/54 | 25 / 78 | 20 / 56 | 64 / 188 | 17.93 | 22.14 | 28.07 | 35.45 |
| #7 - **Chlamydia Screening:** Patient(s) 16 - 24 years of age that had a chlamydia screening test in last 12 reported months | Adherence Rate (%) | 60.71 | 51.46 | 58.90 | 56.68 | 241/397 | 264 / 513 | 288 / 489 | 793 / 1399 | 50.97 | 57.15 | 63.72 | 68.81 |
| #8a - **Developmental Screening:** Patients that had a developmental screening between 0 and 12 months | Adherence Rate (%) | 21.25 | 48.84 | 33.02 | 37.99 | 17/80 | 84 / 172 | 35 / 106 | 136 / 358 | 10.40 | 18.70 | 54.30 | NR |
| #8b - **Developmental Screening:** Patients that had a developmental screening between 13 and 24 months | Adherence Rate (%) | 44.44 | 55.84 | 54.55 | 52.90 | 52/117 | 129 / 231 | 102 / 187 | 283 / 535 | 10.70 | 20.60 | 44.80 | NR |
| #8c - **Developmental Screening:** Patients that had a developmental screening between 25 and 36 months | Adherence Rate (%) | 26.61 | 44.74 | 45.95 | 40.97 | 33/124 | 102 / 228 | 85 / 185 | 220 / 537 | 7.30 | 13.40 | 32.40 | NR |
| #8d - **Developmental Screening:** Patients that had a developmental screening between 0 and 36 months (composite) | Adherence Rate (%) | 31.78 | 49.92 | 46.44 | 44.69 | 102/321 | 315 / 631 | 222 / 478 | 639 / 1430 | 9.47 | 17.57 | 43.83 | NR |

Other Year 1 DLTSS = the population of Medicaid members eligible for attribution but not attributed to either CHAC or OneCare in 2014

NR = Benchmark not reported

***** For Core Measure 1, lower numbers indicate higher performance.

Core Measures 1-7 are HEDIS.

Core Measure 8 Technical Specifications are The Center of Medicare and Medicaid Services Initial Core Set of Children's Health Care Quality Measures.

Core Measure 8 originally developed as part of the Oregon Health & Science University, Child and Adolescent Health Measurement Initiative (CAHMI).

Core Measure 8 descriptions align with CMS specifications to clarify that each indicator reports numerator for a single year in which child is that age.

Core Measure 8 benchmarks are from the Mathematica analysis of FFY 2013 Child CARTS reports. Benchmarks are not applicable to all states. These benchmarks are listed for reference only; ACO performance will be compared to prior year performance for this measure.

The 25$^{th}$, 50$^{th}$, 75$^{th}$, and 90$^{th}$ percentile results come from NCQA's 2013 National Quality Compass results for Medicaid HMOs.

**Calculation Reference**

Observed Readmission Rate = (Number of Patients over 18 readmitted within 30 days of discharge / All Patients discharged)

Adherence Rate (%) = Adherent Members / Eligible Members

Per 100,000 Member Years = (Discharges / Eligible Population Member Years) * 100,000

## Medicaid DLTSS Study: Year 1 (2014) -- Reporting Measures

*(Time period: 01/01/14 to 12/31/14)*

| Measure and Detailed Description | Unit of Measurement | Rate | | | | Numerator/ Denominator | | | | 2013 HEDIS National Medicaid Benchmarks | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | CHAC Year 1 DLTSS | OneCare Year 1 DLTSS | Other Year1 DLTSS | OVERALL Year 1 DLTSS | CHAC Year 1 DLTSS | OneCare Year 1 DLTSS | Other Year1 DLTSS | OVERALL Year 1 DLTSS | 25th | 50th | 75th | 90th |
| **CLAIMS-BASED REPORTING MEASURES** | | | | | | | | | | | | | |
| #10*- **Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults:** Hospitalizations for chronic obstructive pulmonary disease (COPD) or asthma | Per 100,000 Member Years | 1,017.44 | 1,366.12 | 743.49 | 1,072.52 | 7/688 | 10 / 732 | 4 / 538 | 21 / 1958 | No Benchmark Available | | | |
| #11- **Breast Cancer Screening:** Patient(s) 50 - 74 years of age that had a screening mammogram in last 27 reported months | Adherence Rate (%) | 54.05 | 55.95 | 48.00 | 53.37 | 80/148 | 94 / 168 | 48 / 100 | 222 / 416 | 51.21 | 57.42 | 65.12 | 71.35 |
| #12* - **Prevention Quality Chronic Composite (PQI 92):** Hospitalizations for ambulatory care-sensitive conditions | Per 100,000 Member Years | 903.49 | 1,128.84 | 638.98 | 903.41 | 22/2,435 | 29 / 2,569 | 14 / 2,191 | 65 / 7195 | No Benchmark Available | | | |
| #13 - **Pharyngitis, Appropriate Testing for Children:** Patients treated with an antibiotic for pharyngitis who had a Group A streptococcus test | Adherence Rate (%) | 79.37 | 82.78 | 79.85 | 80.90 | 100/126 | 274 / 331 | 329 / 412 | 703 / 869 | 60.96 | 70.22 | 77.89 | 85.09 |

Other Year 1 DLTSS = the population of Medicaid members eligible for attribution but not attributed to either CHAC or OneCare in 2014

***** For Core Measures 10 and 12, lower numbers indicate higher performance.

Core Measures 11 and 13 are HEDIS.

Core Measures 10 and 12 are AHRQ Prevention Quality Indicators (PQI) measures.

The 25$^{th}$, 50$^{th}$, 75$^{th}$, and 90$^{th}$ percentile results come from NCQA's 2013 National Quality Compass results for Medicaid HMOs.

**Calculation Reference**

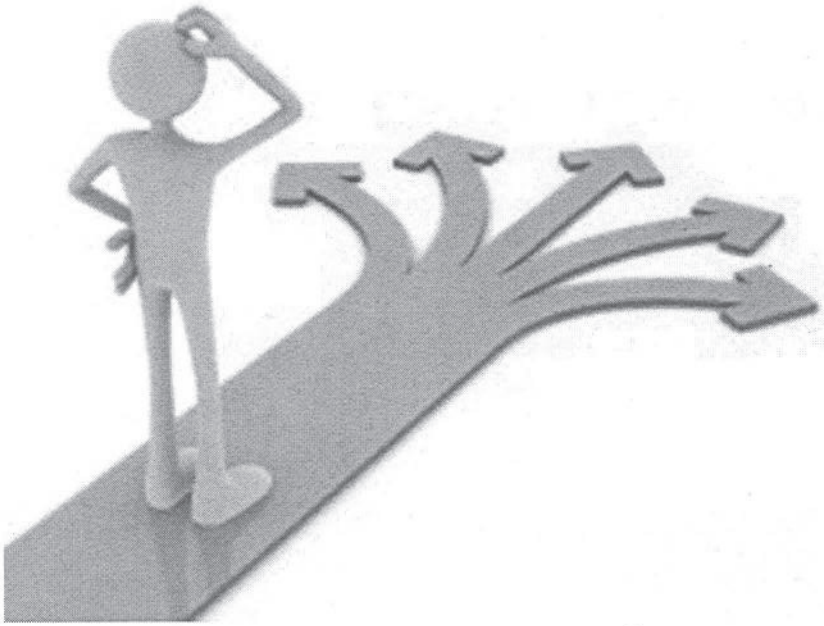
Per 100,000 Member Years = (Discharges / Eligible Population Member Years) * 100,000

Adherence Rate (%) = Adherent Members / Eligible Members

# Attachment 4a - DS Overview of Medicaid Pathway

# MEDICAID PATHWAY

*DISCUSSION DRAFT*



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# Medicaid Pathway

**What is it?**

- It refers to several critical ideas:
  - There is payment and delivery system reform that must happen alongside the all-payer model (APM) regulated revenue/cap conversation.
  - There is a process for Medicaid providers to engage in with the State alongside the APM regulated revenue/cap conversation.
  - This process is led by AHS-Central Office in partnership with the Agency of Administration and includes Medicaid service providers who provide services that are not included in the initial APM implementation, such as LTSS, Mental Health, substance abuse services and others.
  - The Medicaid Pathway advances payment and delivery system reform for services not subject to the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care.

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# Medicaid Pathway in Perspective

**Big Goal:**

Integrated health system able to achieve the triple aim

- ✓ Improve patient experience of care
- ✓ Improving the health of populations
- ✓ Reduce per capita cost

**Implementing Next Generation ACO Type Capitated Payment Model:**
Way to pursue goal of integrated system for certain services and providers.

Implementation led by DVHA with support from others.

**Medicaid Pathway:**

Task of pursuing goal of integrated system for services not subject to financial caps of all-payer model.

AHS led project that interacts with ongoing AHS reform efforts and SIM.

**CRITICAL TAKE-AWAY:** Implementation of a Medicaid Next-Gen ACO that provides a sub-set of Medicaid services and is subject to financial caps is only one piece of the all-payer model and envisioned delivery system reforms.

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# Medicaid Pathway Process

**Delivery System Transformation (Model of Care)**

- What will providers be doing differently?
- What is the scope of the transformation?
- How will transformation support integration?

**Payment Model Reform (Reimbursement Method, Rate Setting)**

- What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
- Rate setting to support the model of care, control State cost and support beneficiary access to care
- Incentives to support the practice transformation

**Quality Framework (including Data Collection, Storage and Reporting)**

- What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?

**Outcomes**

- Is anyone better off?

**Readiness, Resources and Technical Assistance**

# Resource Slide: Key Terms and Concepts

- All-payer model: catch all term to describe (1) an agreement with CMS that waives federal laws so that (2) Medicare will pay a capitated payment to an ACO for hospital and physician services in exchange for (3) a State commitment to meet financial targets and quality goals. The State would then (4) align commercial insurers and Medicaid to pay the ACO the same way as Medicare.
- Next Generation: a Medicare ACO program that offers several waivers and four payment models, including a capitated payment. Next Generation provides the programmatic base for the all-payer model.
- Regulated revenue: the covered services and revenue within the all-payer model and subject to the financial and quality targets.
- Medicare infrastructure waivers: a fancy way of saying that we are asking Medicare to (1) keep making Blueprint payments, (2) expand SASH, and (3) invest in Hub and Spoke.
- All-payer financial targets: Limitation on spending for services and spending inside the all-payer model. The target is 3.5% and ceiling 4.3%. These numbers are limits, not guaranteed annual revenue increases to providers participating in the model. The State proposed a floor as well, a minimum rate of Medicare growth. This protects the State against unexpectedly low Medicare growth.
- Medicaid Pathway: a process through which AHS advances payment and delivery system reform outside of the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care

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# Attachment 4b - CFC MOC Opportunities 9-21-16

# Choices for Care Program: Opportunities for Improvement

September 21, 2016

Stakeholder Work Group Discussion

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

# Presentation Topics

- Vermont Model of Care
  - Model of Care/Choices for Care (CFC) Overview
  - CFC Program Improvement Feedback
    - Model of Care and CFC Improvement Areas
  - CFC Delivery and Payment Reform Opportunities
  - CFC Opportunities and Performance Measures
  - Discussion and Next Steps

# Model of Care & CFC Crosswalk

| Model of Care Elements | Choices for Care |
|---|---|
| Person Centered and Directed Process for Planning and Service Delivery | ✓ |
| Access to Independent Options Counseling & Peer Support | ✓ |
| Actively Involved Primary Care Physician | Partial |
| Provider Network with Specialized Program Expertise | ✓ |
| Integration between Medical & Specialized Program Care | Partial |
| Single Point of Contact for persons with Specialized Needs across All Services | ✓ |
| Standardized Assessment Tool | ✓ |
| Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services | Partial |
| Care Coordination and Care Management | ✓ |
| Interdisciplinary Care Team | No |
| Coordinated Support during Care Transitions | ✓ |
| Use of Technology for Sharing Information | No |

# CFC Program Improvement Feedback

- Feedback solicited from stakeholders and DAIL staff regarding opportunities to improve the Choices for Care (CFC) program
- Feedback compiled and analyzed by Model of Care (MOC) elements and potential reform area
  - Additional feedback compiled related to self-directed care
- Opportunities identified for CFC delivery and payment model reform

# CFC Program Improvement Feedback

- Potential Reform Area
  - *State Policy and Resource Needs* – changes in standards, certifications, program rules or guidelines, coverage policies; or gaps in current benefits, need for more resources, training or specialized programs;
  - *Delivery and Payment Model* – revisions or modification to practice or service delivery, timing or location of services; or revisions to the manner in which providers are paid for services;
  - *Medicare /ACO Alignment* – Medicare or hospital and PCP related policies, benefits or practices that could support and/or improve CFC service delivery.

# Model of Care & CFC Feedback

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 1. Person Centered and Directed Process for Planning and Service Delivery | Consistent and timely access to person-centered planning during hospital or nursing facility discharge | | D, P | ✓ |
| | Enhancement of person-centered planning | P | D | |
| | Development and implementation of person-centered planning tools | P | D | ✓ |
| | Training for Case Managers and other staff (e.g., hospital social workers, transition II advisors, AFC service coordinators) | R | D | ✓ |
| 2. Access to Independent Options Counseling & Peer Support | Consistent and timely access to independent Options Counseling (ADRC) during hospital and/or short term rehabilitation nursing facility stays | | D | ✓ |
| | Improve access to plan of care/person-centered information gathered during ADRC options counseling and potential for incorporation into Independent Living Assessment (ILA) and other planning | | D | ✓ |
| | Expansion of ADRC Options Counseling in all settings (prior to CFC and/or other application processes) | R | D | ✓ |

# Model of Care & CFC Feedback(cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 3. Actively Involved Primary Care Physician | Expand and improve PCP involvement in overall care plan | P, R | D | ✓ |
| | Develop health and wellness standards (similar to DDS guidelines) for CFC providers to use in order to monitor primary care needs | P | D | ✓ |
| | Increase access to preventive care, wellness programs, nutritional services and exercise options to support health and independence | R | D, P | ✓ |
| | Home visits by PCP and team approach to health and well-being | P, R | D, P | ✓ |

# Model of Care & CFC Feedback (cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 4. Provider Network with Specialized Program Expertise | Increase training and certifications for in-home providers | P, R | | |
| | Improve out of home respite options | R | | |
| | Improve staffing for home based care | | D, P | |
| | Explore training options to enhance care-giver skills and support to prevent burnout | R | | |
| | Consider expanded access to non-medical personal care services | R | D | |
| | Enhance options for customized community programming in addition to adult day | R | | |
| | Explore specialized adult day programming (e.g., supporting people with dementia care needs, psychiatric management needs and/or challenging behaviors) | R | | |
| | Improve access to mental health and substance abuse services including medication-assisted treatment | R | D, P | ✓ |
| | Provide Mental Health consultation in Nursing Facilities | R | D, P | ✓ |
| | Explore how to address and/or develop resources for specialized care needs (bariatric, dementia, behavioral health care) | R | D, P | ✓ |
| | Integrate and improve options for persons with a TBI within the CFC program | P | D, P | |

# Model of Care & CFC Feedback(cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 5. Integration between Medical & Specialized Program Care | Opportunity to identify potential CFC enrollees and assist persons to maintain independence through PCP coordination and early assessments | P, R | D, P | ✓ |
| | Support earlier application for specialized programs (e.g., on hospital admission) | | D | ✓ |
| | Discharge processes that allows for timely identification of Adult Family Care and/or in-home support needs to allow for community-based staff recruitment and training | | D | ✓ |
| | Increase access to preventive care and health promotion (public health, wellness, nutritional and exercise support) and support services that allow people to age in place (transportation, PCP home visits, heat, food, and housing) | | D, P | ✓ |
| 6. Single Point of Contact for Persons with Specialized Needs Across All Services | Support for caregivers who are unable to find respite | R | D | ✓ |
| | Improve coordination of in-home care (e.g., PCA, respite staff) | | D | ✓ |
| | Increase assistance with ancillary support needs (e.g., heat, food, housing, transportation) | | D | ✓ |

# Model of Care & CFC Feedback(cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 7. Standardized Assessment Tool | ILA tool is outdated, new tool that more effectively addresses person-centered planning and specific challenges such as dementia, substance abuse, mental illness, cognitive impairments are needed | P, R | D | ✓ |
| | Consider risk mitigation tools and negotiated risk agreements | P | D | |
| | Standardized electronic tools need to easily convert information into usable format for data collection, storage and reporting (e.g., outcome tracing and plan of care performance measures) | P, R | D | ✓ |

# Model of Care & CFC Feedback(cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 8. Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services | Choices for Care plan typically include service authorization but not comprehensive inclusion of all needs and supports and person-centered goals | P | D, P | |
| | Improve budget flexibility for self-directed participants | P | D, P | |
| | Moderate Needs Group funding is fragmented and not always conducive to person-centered planning or early intervention for persons at risk for NF placement | P | D, P | |
| | Medicare and commercial payers coverage policies exclude LTSS | | | ✓ |
| | Mental and Substance Abuse Treatment service is not well coordinated; screening and access to service could be improved | P, R | D, P | |
| | Coverage policies will not allow concurrent NF and Specialized community provider services (DA/SSA, TBI, ADAP) services | P, R | D, P | ✓ |
| | Coverage policies limit companion/respite hours per calendar year; many participants with dementia, psychiatric, behavioral or other high needs require more hours | P, R | | |
| | Assistive Device/Home Modifications Assisted Technology needs are determined by case manager, however low Medicare rates for DME discourage providers from accepting Medicare and create a need for CFC funds to be used for DME | | D, P | ✓ |
| | Lack of PCAs to staff total hours called for within care plans | R | D, P | ✓ |
| | Eligibility for personnel emergency response system (PERS) service and cost of service | P, R | D, P | ✓ |
| | Access to reliable transportation | R | D, P | ✓ |
| | Increase access to programs that provide skill-building for independence in the community (functional capacity and daily living support) | R | D, P | ✓ |
| | Increase utilization of hospice care (e.g., increase VT utilization to national average) | | D | ✓ |

# Model of Care & CFC Feedback(cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 9. Care Coordination and Care Management | DAIL approved activities are limited | P | D | |
| | Annual limit of 48 hours per calendar year unless variance requested restricts services for enrollees with more complex needs | P, R | D, P | |
| | Training in specialized care issues is needed (e.g., dementia, psychiatric and behavioral challenges) | R | D | ✓ |
| | Improve more formal linkage and seamless services between CFC case management agencies and other disability services (e.g., DA/SSA and TBi systems) | | D | ✓ |
| | Allow nurse monitoring between Medicare episodes of care to assist persons to maintain independence and safety at home | R | D | ✓ |
| | Add a Targeted Case Management option for Medicaid enrollees who may be at risk but not yet part of the CFC program | R | D, P | ✓ |
| 10. Interdisciplinary Care Team | Develop CFC team approach to support more comprehensive care planning to address individual needs | P | D, P | |

# Model of Care & CFC Feedback (cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Model of Care Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| 11. Coordinated Support during Care Transitions | Improve provider coordination between care transitions | | D, P | |
| | Staffing shortages often delay transitions from facility based care to in-home or AFC settings | | D, P | |
| | Enrollees who choose ERC & AFC services do not have case management services outside of all-inclusive daily rate; this can be a barrier to seamless transition from nursing facility or hospital | | D, P | ✓ |
| | Medications are not reconciled post discharge from hospital or NF due to staff shortages and Medicare delegation rules | | D, P | ✓ |
| 12. Use of Technology for Sharing Information | Better communication between providers and readily accessible records information across providers | | D | ✓ |
| | SAMS does not support sharing of information with hospitals and primary care or internal DAIL connection to LTSS Eligibility files | R | | |

# Model of Care & CFC Feedback(cont'd)

| Summary of LTSS/CFC Staff and Stakeholder Feedback by Reform Area | | | | |
|---|---|---|---|---|
| Feedback Area | Areas for LTSS/CFC Improvement | Potential Reform Area | | |
| | | State Policy (P) or Resource (R) | Local Delivery (D) or Payment (P) Model | Medicare/ACO Alignment Item |
| Other CFC: Self- Directed Care | Improve assessment and certification processes for determining who is eligible to self-manage | P, R | D | |
| | Improve support to self-directed participants (e.g., respite, caregiver support, employer roles) | R | | |
| | Re-examine fiscal intermediary (e.g., pass-through) role for improvements across all populations | P | D | |
| | Improve training and support for individual and families who self-manage paid caregivers | R | | |
| | Improve access to care provider resources, e.g., improved the functionality of the care giver registry | R | | |

# Model of Care & CFC Opportunities

1. ***Improve Early Options Counseling and Assessment***: Support early ADRC Options Counseling and holistic screening, and assessment for specialized needs in all settings (e.g., PCP, hospital admission, Nursing Facilities, Blueprint screening, referral and/or co-location agreements for ADRC and other CFC staff in non-CFC settings)
   (Model of Care Elements 1, 2, 7, 11)

2. ***Enhance Service Delivery Flexibility***: Increase program flexibility for providers to match service and staffing to person-centered plan, including funding allocations for moderate needs group programming through approval of overall budget or package of services for homemaker, respite, companion, PCA (e.g., eliminate hourly service limits) and other enrollee services and supports
   (Model of Care Elements 1, 4, 5, 8, 11)

3. ***Create Interdisciplinary Teams***: Implement interdisciplinary teaming and improve coordination of in-home care (e.g., PCA, respite staff), ancillary support needs (e.g., heat, food, housing, transportation) and increase support during care transitions
   (Model of Care Elements 1, 3, 5, 7, 8, 9, 10, 11, 12)

4. ***Improve Integration***: Improve more formal linkage and seamless services between CFC case management agencies and mental health, substance abuse and other disability service providers to address specialized health needs
   (Model of Care Elements 1, 4, 5, 6, 8, 9, 10, 11, 12)

# CFC Delivery & Payment Opportunities

| Choices for Care Program Medicaid Opportunities for Delivery and Payment Reform | | |
|---|---|---|
| **Opportunity** | **Payment Model Options** | **VT Integrated Care Model Examples** |
| 1. *Improve Early Options Counseling and Assessment:* | Targeted Case Management or Nurse Monitoring reimbursement option for persons with complex needs who are not yet part of the CFC program (e.g., monitoring between episodes of care)<br><br>Enhanced Care Coordination agreements payments between hospital, ADRC and HHA/AAA to support timely options counseling, discharge and planning | *Interdisciplinary Team Models:*<br>o Specialized Health Home (e.g., Medication Assisted Treatment for Opioid Addiction Hub and Spoke)<br>o Patient Centered Medical Homes (e.g., Blueprint for Health)<br>*Enhanced Care Coordination*<br>o Community Health Teams (FTE care managers assigned to PCP practices)<br>o Vermont Chronic Care Initiative (FTE care managers assigned to payers and regions)<br>o Targeted case management (e.g., SASH)<br>o Co-location of staff in PCP practices or other affiliation agreements (e.g., Health First and Burlington Community Health Center partnership)<br>*Provider-led Models*<br>o Accountable Care Organization (ACO)<br>o Unified Community Collaborative (UCC)<br>o Accountable Communities for Health (ACH)<br><br>*Other?* |
| 2. *Enhance Service Delivery Flexibility* | Case rate or bundled payment for HCBS services<br>o Highest/High Group;<br>o Moderate Needs Group; and<br>o Assistive technology, home modifications, other devices<br><br>Incentives for regions that improve on the numbers of persons receiving supports and services in home and community settings of their choosing | |
| 3. *Create Interdisciplinary Teams* | PMPM payment to each case management agency (or a single lead entity) for all identified CFC enrollees in a defined region | |
| 4. *Improve Integration* | | |

# CFC Opportunities & Performance

- Compilation of existing and proposed LTSS/CFC performance and outcome measures
- Feedback solicited from stakeholders regarding “top ten” most preferred measures that could be used to gauge success of Medicaid Pathway CFC enhancements
- Ten measures with the most votes reviewed for alignment with Model of Care and CFC opportunities

# CFC Opportunities & Performance

| Top 10 Performance and Outcome Indicators | | |
|---|---|---|
| **Performance and Outcome Indicators** | **Model of Care Element** | **Opportunity for Improvement** |
| 1. Involvement in plan of care development and decision making | o Person Centered and Directed Process for Planning and Service Delivery | o Improved flexibility for providers to match services to person-centered needs could improve enrollee involvement, engagement and decision-making |
| 2. Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need | o Access to Independent Options Counseling & Peer Support<br>o Person Centered and Directed Process for Planning and Service Delivery | o Delivery system improvements that support early options counseling and holistic screening and assessment for specialized needs could support improved and earlier access through co-location and/or other integration agreements |
| 3. Participant's medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed<br><br>4. Reduction in avoidable hospital admissions/re-admissions<br><br>5. Reduction in emergency room visits | o Actively Involved Primary Care Physician<br>o Provider Network with Specialized Program Expertise<br>o Integration between Medical & Specialized Program Care<br>o Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services | o Supporting an interdisciplinary team approach and enhanced care coordination between medical and specialized providers could improve utilization of potentially avoidable services |

# CFC Opportunities & Performance(cont'd)

| Top 10 Performance and Outcome Indicators | | |
|---|---|---|
| **Performance and Outcome Indicators** | **Model of Care Element** | **Opportunity for Improvement** |
| 6. Proportion of people who have transportation to get to medical appointments when needed | o Single Point of Contact for person with Specialized Needs across All Services<br>o Integration between Medical & Specialized Program Care<br>o Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services | o Enhanced teaming and care coordination could improve communication and identification of scheduling needs to lessen gaps in transportation |
| 7. Participants report that their quality of life improves<br>8. Stable community living situation and/or reduction in homelessness | o Standardized Assessment Tool<br>o Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services | o Improvements in comprehensive assessment, person-centered planning and service delivery could result in improved quality of life, including improved stability of living situations |
| 9. Satisfaction regarding care coordination and access | o Care Coordination and Care Management<br>o Interdisciplinary Care Team | o Improvements in care coordination and interdisciplinary teaming could result in increased satisfaction and improved access to necessary care |
| 10. Support during care transitions | o Coordinated Support during Care Transitions<br>o Use of Technology for Sharing Information | o Improvements in communication and information sharing and early support for transitions could result in improved stability |

# Discussion

1. Will the four identified opportunities lead to meaningful improvement in the CFC program?

2. Are there additional CFC opportunities to consider?

3. What integrated care model designs (e.g., Health Home, ACO, Community Health Team) would best support the four identified CFC opportunities?

# Next Steps

Topics for Discussion

- CFC Program Overview
  - Services and claims data
- Integrated Care Models
  - What model(s) will best support CFC?
  - What models align with HCBS rules and VT policy?
- Payment Model Options
  - What options best support integrated care, VT Model of Care, desired CFC improvements and HCBS standards?
- Delivery and Payment Design Recommendations

# Attachment 5a - VT AP ACO MODEL Final 9 29 2016

# VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL

## SEPTEMBER 28, 2016

# Overview

Status of Agreements & Calendar of Events

What Problems Are We Trying to Fix?

Key Terms and Acronyms

All-Payer Model Draft Agreement

- State Action on Financial and Quality Targets
- Opportunity for Providers through an Accountable Care Organization
- Resources for Reform and the Global Commitment for Health Medicaid Waiver
- Why the Model is Good for Patients and Providers

Questions

# Status of the Agreements

- All-Payer Model Draft Agreement
  - Vermont and CMMI have reached a ***draft, preliminary*** agreement on the concept and key terms.
  - The next step is a public process to determine if the state should sign the agreement.
  - The draft is currently under legal review by both the State and CMS. The language in the draft released today will change as part of the legal review. The concepts will not.
  - If agreed to, the Agreement would be signed by the Governor, the Secretary of Human Services, and the Chair of the GMCB, after a GMCB vote.

- Global Commitment Medicaid Waiver
  - AHS and CMCS have reached a verbal agreement on the terms of a waiver, but the complete, detailed, written terms and conditions are still in federal clearance at this time.

# Calendar of Events

- Green Mountain Care Board Meetings – 89 Main Street, City Center, 2nd floor:
  - Thursday, Sept 29th 1 pm
  - Wednesday, Oct 5th 9 am
  - Thursday, Oct 13th 1 pm

- 3 Public Forums in the coming weeks, details coming shortly
  - Chittenden/Franklin area
  - Rutland area
  - Upper Valley area

- Information will be posted at gmcboard.vermont.gov and hcr.vermont.gov

# What Problems Are We Trying To Fix?

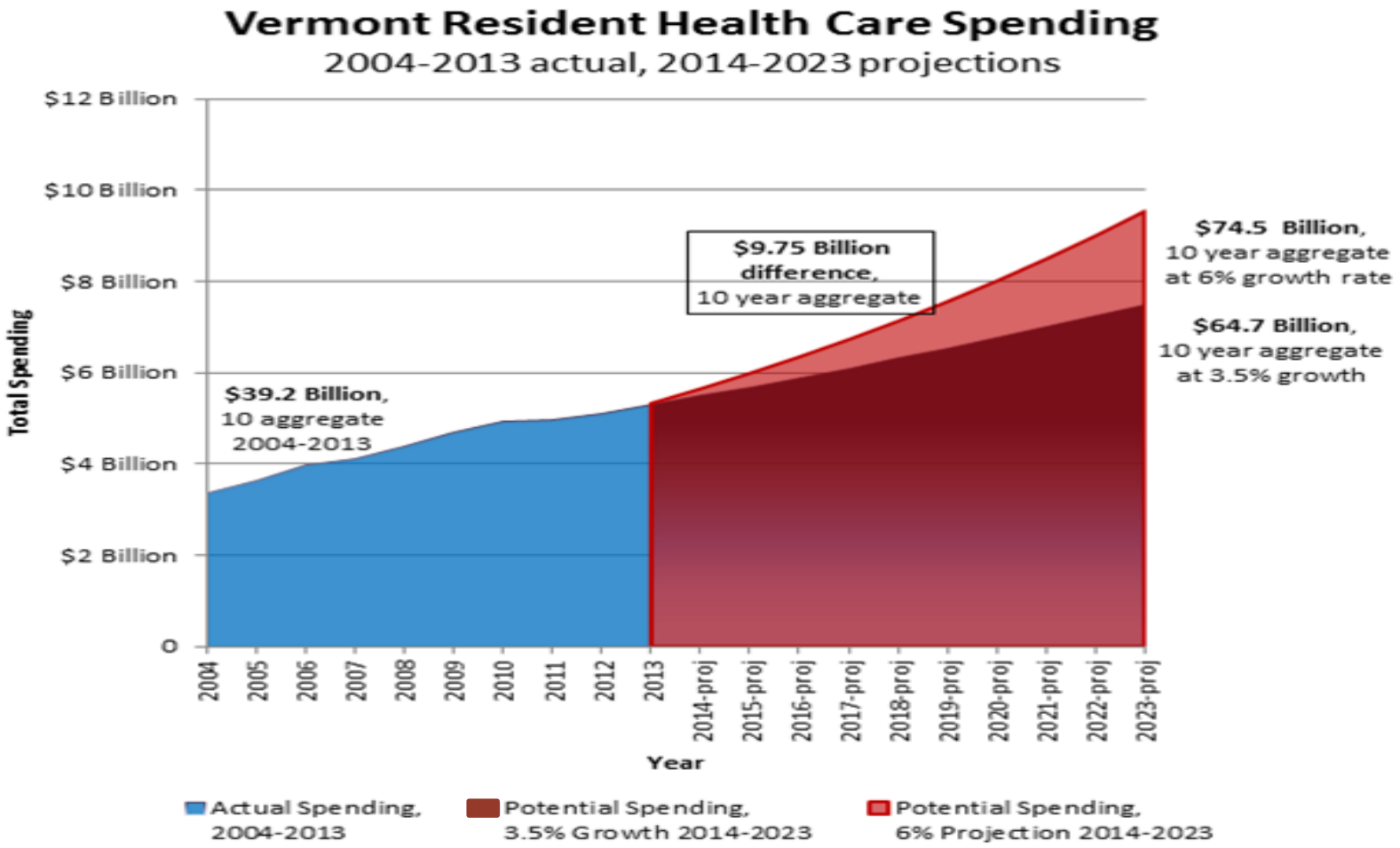
- Increasing health care costs, rising faster than economic growth
  - In 2014, the most recent year of data available, health care spending in Vermont grew 4.6%.
  - In the same year, GSP grew only 2.4%.

- Health Outcomes Need to Improve
  - Vermonters struggle to access primary care.
  - Rate of deaths due to suicide and drug overdose are too high in Vermont.
  - Too many Vermonters suffer chronic disease, and everything that goes with it.

# Income Vs. Health Care Costs

| | 2015 | 2025 |
|---|---|---|
| Income | $60,000 | $73,140 |
| Hourly Pay | $30 | $36.57 |
| Plan Cost/Hour | $11.52 | $19.83 |
| Plan Cost/Hour with Subsidy | $5.92 | $8.81 |
| Plan Cost per Year | $23,957 | $41,253 |
| Cost/Income | 38% | 56% |

# What problem are we trying to solve?






VERMONT
HEALTH CARE REFORM

## Big Goal:

Integrated health system able to achieve the triple aim

- ✓ Improve patient experience of care
- ✓ Improve the health of populations
- ✓ Reduce per capita cost growth

### All-Payer Model Agreement

- Vermont's potential contract with the federal government for how the All-Payer Model will be administered
- Provides framework to align payers
- Sets targets for quality and total cost of care expenditures

### Global Commitment to Health 1115 Waiver

- Vermont's contract with the federal government for how Medicaid will be administered
- Provides framework to align Medicaid with other payers
- Financial and program flexibility to drive innovation

# Key Terms & Acronyms

**Accountable Care Organization or ACO:** An entity, formed by certain health care providers and suppliers that accepts financial accountability for the overall quality and cost of medical care furnished to, and health of, beneficiaries attributed to the entity.

**All-payer Total Cost of Care:** The total expenditures associated with All-payer Financial Target Services (roughly equivalent to Medicare Parts A and B).

**Medicare Part A (Hospital Insurance):** Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

**Medicare Part B (Medical Insurance):** Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

**Medicare Access and Children Health Insurance Program Reauthorization Act (MACRA) :** a new federal law in 2015, which creates two payment reform programs for Medicare. These are: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs). MIPS and AAPM provides financial incentives for physician's office who participate in payment reform or quality programs. There are financial disincentives for physicians who do not participate.

# VT All-Payer ACO Model Draft Agreement: Framework for Transformation

- State action on financial trends & quality measures
  - Moves from volume-driven fee-for-service payment to a value-based, pre-paid model for Accountable Care Organizations (ACOs).
    - Sets All-Payer Growth Target: 3.5%
    - Medicare Growth Target: 0.1-0.2% below national
  - Requires alignment across Medicare, Medicaid, and participating Commercial payers.

- Goals for improving the health of Vermonters
  - Improve access to primary care.
  - Reduce deaths due to suicide and drug overdose.
  - Reduce prevalence and morbidity of chronic disease.

# Opportunities for Providers Through an ACO

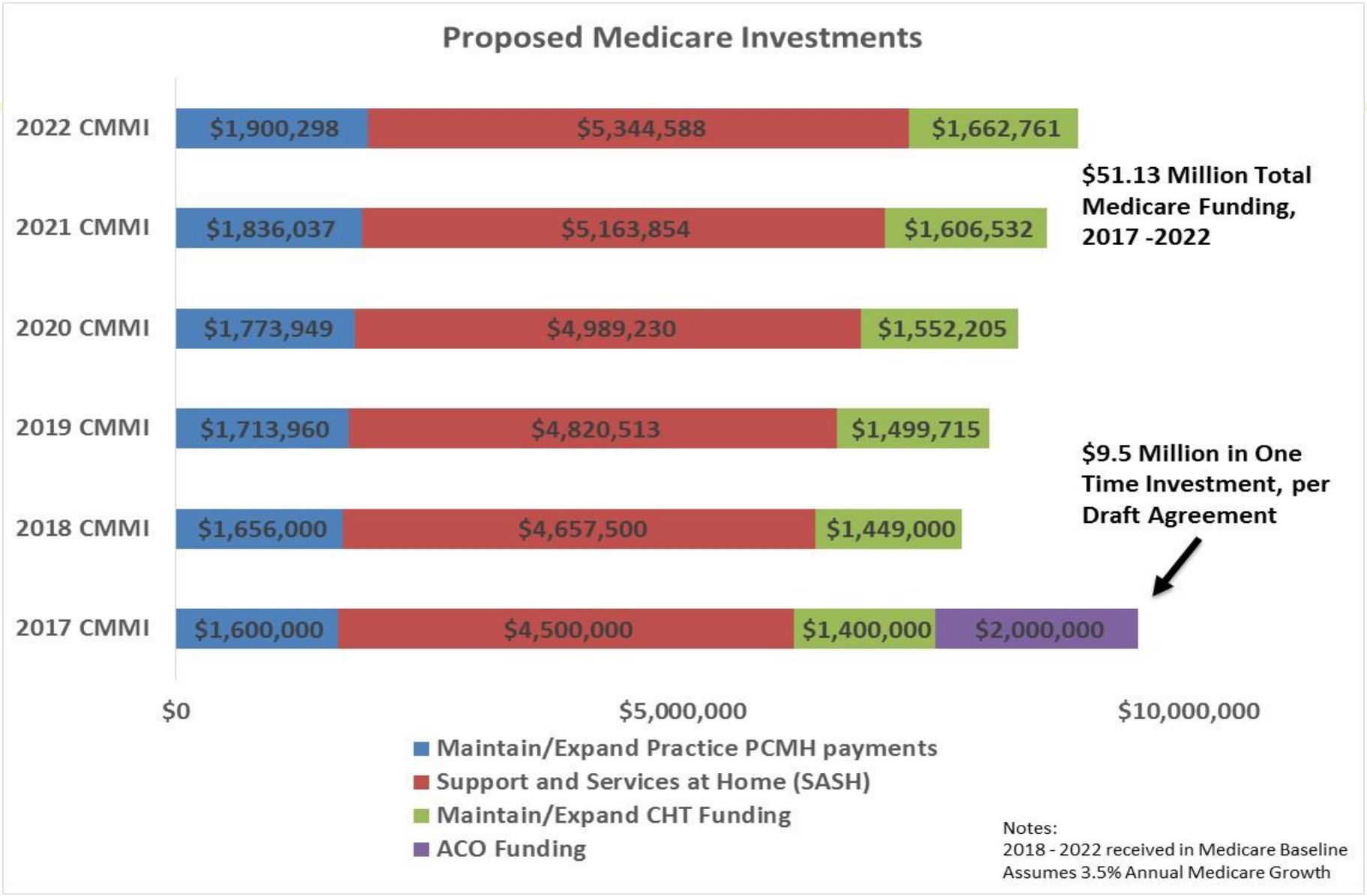
- Allows some providers to continue to participate in Medicare program without taking on risk.
  - Medicare Shared Savings Program

- Allows providers to earn incentive payments in Medicare's new payment model in a way that is consistent with the goals of the Secretary of Health and Human Services, yet customized to Vermont.
  - Medicare Next Generation-Style ACO Program
    - Vermont trend
    - Vermont quality measures
    - Full capitation (Pre-paid model)

- Medicaid Next Generation-Style ACO Program.
  - Aligned with Medicare

# Resources for Reform

- Extends Medicare participation in the Blueprint for Health, Vermont's nationally recognized initiative transforming primary care.
- Continues federal Medicare funding for the Services and Supports at Home (SASH) program, which has a track record of saving money while keeping seniors in their homes and out of hospitals.
- Enables Vermont, through its Medicaid waiver, to support investments in the ACO and in community-based providers.
- Opportunity to use remaining State Innovation Model Grant to support transition.






VERMONT
HEALTH CARE REFORM

# Vermont Proposed Medicaid Capacity
## for System Transformation

| | 2017 | 2018 | 2019 | 2020 | 2021 | NEW WAIVER 2022 | TOTAL |
|---|---|---|---|---|---|---|---|
| Advance Consumer Health Engagement | $ 1,000,000 | $ 5,000,000 | $ 4,000,000 | $ 3,000,000 | $ 3,000,000 | $ 3,000,000 | $ 19,000,000 |
| Advanced Community Care/Case Management | $3,000,000 | $ 5,000,000 | $5,000,000 | $ 4,000,000 | $ 3,000,000 | $2,000,000 | $22,000,000 |
| Community Primary and Secondary Prevention | $ 2,000,000 | $ 7,000,000 | $7,000,000 | $ 5,000,000 | $ 3,000,000 | $ 3,000,000 | $27,000,000 |
| Information Infrastructure | $15,000,000 | $ 9,000,000 | $6,000,000 | $ 4,000,000 | $ 4,000,000 | $4,000,000 | $42,000,000 |
| Community based services-Medicaid Pathway | $15,000,000 | $ 12,000,000 | $ 10,000,000 | $ 8,000,000 | $ 6,000,000 | $ 4,000,000 | $55,000,000 |
| Quality and PHM Measurement and Improvement | $ 3,000,000 | $ 8,000,000 | $ 6,000,000 | $ 4,000,000 | $ 2,000,000 | $ 0 | $23,000,000 |
| Socio-Economic Risk and Mitigation | $2,000,000 | $ 5,000,000 | $5,000,000 | $ 4,000,000 | $ 3,000,000 | $2,000,000 | $21,000,000 |
| **Total** | **$41,000,000** | **$51,000,000** | **$43,000,000** | **$ 32,000,000** | **$ 24,000,000** | **$18,000,000** | **$209,000,000** |

- These represent potential, proposed expenditures in Medicaid Programs, Administration and Technology that are under negotiation. All require some level of state dollars in order to draw down federal match.
- Spending would focus on building AHS, GMCB, community service provider, and ACO capacity for reform.



VERMONT
HEALTH CARE REFORM

# How the 1115 Waiver Drives an Integrated Health System

- Allows Vermont Medicaid to design an ACO payment model that aligns with Next Generation.
- Gives Vermont flexibility to design alternative payment models for services that will be integrated into the model over time.
- Provides opportunity for Vermont to draw down federal funding to support the transformation of Vermont's the health care system.
- Positions Vermont to take a "one model" approach across federal payers.
- CMCS and Vermont are aligned conceptually; however, negotiations are not yet complete.

# Why is this Good for Patients?

- Preserves all current beneficiary protections consistent with Medicare, Medicaid, or a Vermonter's commercial coverage plan.
- Medicare offers the opportunity, through an ACO, to receive benefit enhancements:
  - Post-discharge home visit
  - Easier access to Skilled Nursing Care
  - Telemedicine Services
- Encourages health care providers to better coordinate patient care and services.
- May lead to more meaningful time spent with your doctor.
- Links health care outcomes for the population meaningfully with the health care delivery system
- Creates a coordinated public/private approach to improving access to primary care, mental health, and substance abuse services.

# VT All-Payer ACO Model Draft Agreement: Beneficiary Protections

- Medicare and Medicaid beneficiaries keep all their current benefits, covered services, and choice of providers, and an ACO cannot narrow their networks.

- Protects Vermonters with private insurance, with care decisions and provider choice remaining a matter between Vermonters and their insurers.

# Why is this Good for Providers?

- Participation is by choice.
- Removes barriers to practicing in an integrated, coordinated care delivery system.
- Rewards providers for delivering high quality care.
- Rewards providers for improving health outcomes.
- Potential to provide more meaningful time with patients.
- Payment change across all payers may lead to administrative efficiencies.
- Maintains Medicare participation in proven programs to support providers in delivering comprehensive wrap-around care: Blueprint for Health, SASH.
- Creates path to maximize quality performance and reimbursement under new Medicare payment models (MACRA/MIPS).
- Offers participation in a unified, statewide system of care with shared cost moderation and quality improvement goals.

# Questions?

# Attachment 6a - Population Health Plan Overview 9-27-16

# 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)

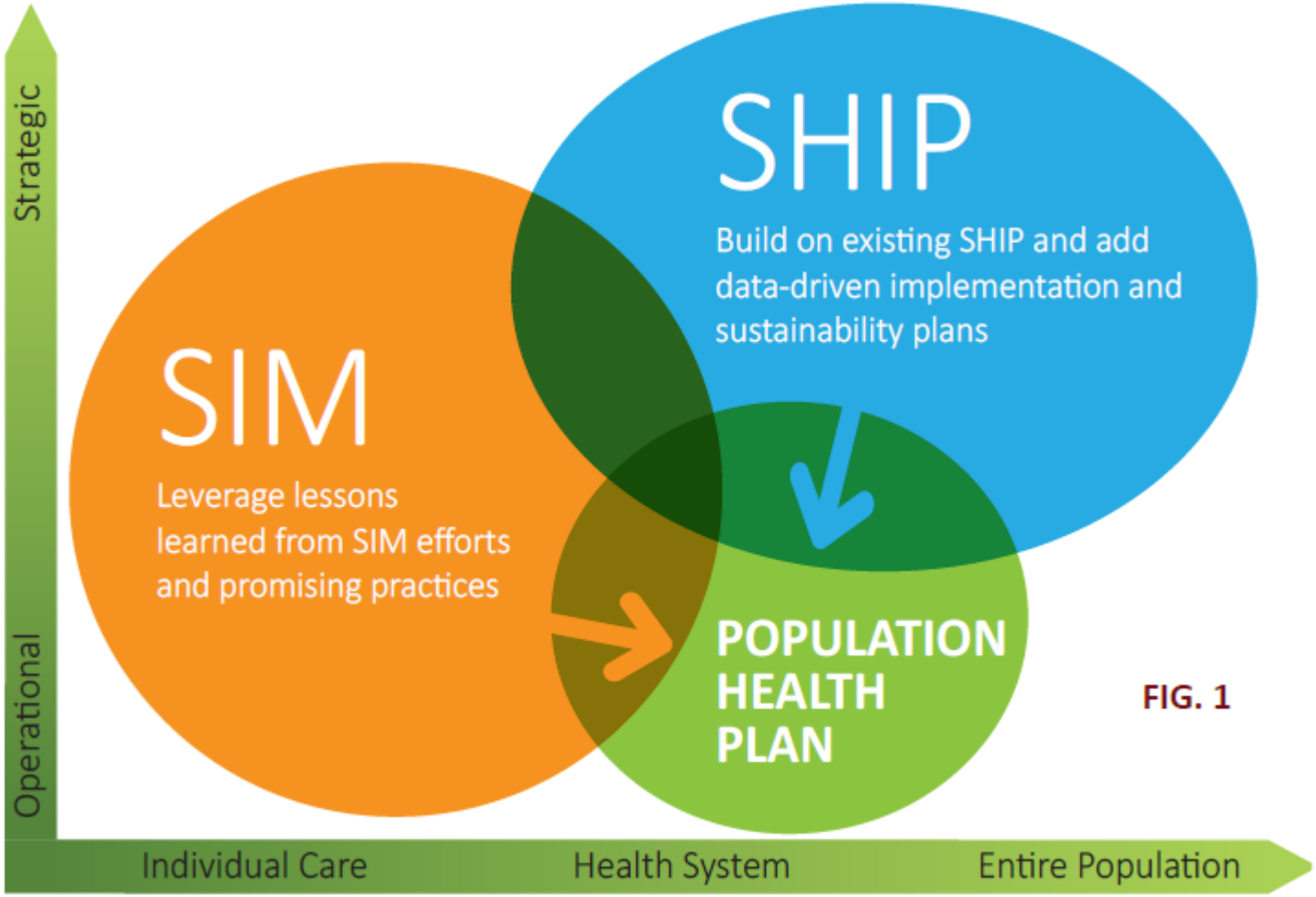



FIG. 1

# 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?