



STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

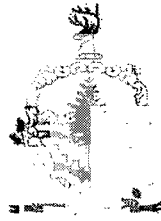
To: James Reardon, Commissioner of Finance & Management
From: Nathan Lavery, Fiscal Analyst
Date: July 11, 2011
Subject: JFO #2510

No Joint Fiscal Committee member has requested that the following item be held for review:

JFO #2510 — \$17,963,059 grant from the U.S. Department of Health and Human Services to the Vermont Department of Disabilities, Aging and Independent Living. These funds will be used to provide people living in nursing facilities the opportunity to live in the community with needed services and supports. The grant supports the “Money Follows the Person” program for Medicaid beneficiaries. Eight (8) limited service position requests are associated with this item.
[JFO received 6/7/11]

The Governor’s approval may now be considered final. Please inform the Secretary of Administration and your staff of this action.

cc: Susan Wehry, Commissioner



STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members
From: Nathan Lavery, Fiscal Analyst
Date: June 15, 2011
Subject: Grant Requests

Enclosed please find three (3) grants/donations that the Joint Fiscal Office has received from the administration. Eight limited service positions are associated with these items.

JFO #2508 — \$15,000 donation from Ross and Gail Anderson to the Department of Fish and Wildlife. This donation represents the difference between the appraised value of the property (207.8 acres in Addison) being sold to the State of Vermont and the purchase price of the parcel. Because the state is not paying the full appraised value, the difference is considered a donation to the state of Vermont. **Expedited review of this item has been requested. Joint Fiscal Committee members will be contacted by June 24 with a request to waive the balance of the review period and approve acceptance of this item.**

[JFO received 6/7/11]

JFO #2509 — \$56,800 donation from Batten Kill Watershed Alliance to the Department of Fish and Wildlife. This donation represents the estimated town assessed value of the property (two parcels totaling 3.2 acres in Arlington) being donated to the State of Vermont. **Expedited review of this item has been requested. Joint Fiscal Committee members will be contacted by June 24 with a request to waive the balance of the review period and approve acceptance of this item.**

[JFO received 6/7/11]

JFO #2510 — \$17,963,059 grant from the U.S. Department of Health and Human Services to the Vermont Department of Disabilities, Aging and Independent Living. These funds will be used to provide people living in nursing facilities the opportunity to live in the community with needed services and supports. The grant supports the "Money Follows the Person" program for Medicaid beneficiaries. Eight (8) limited service position requests are associated with this item.

[JFO received 6/7/11]

Please review the enclosed materials and notify the Joint Fiscal Office (Nathan Lavery at (802) 828-1488; nlavery@leg.state.vt.us) if you have questions or would like an item held for legislative review. Unless we hear from you to the contrary by June 24 we will assume that you agree to consider as final the Governor's acceptance of these requests.

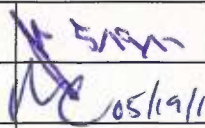
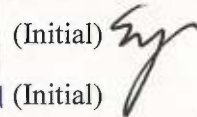
State of Vermont
 Department of Finance & Management
 109 State Street, Pavilion Building
 Montpelier, VT 05620-0401

Agency of Administration

[phone] 802-828-2376
 [fax] 802-828-2428

JFO 2510

**STATE OF VERMONT
 FINANCE & MANAGEMENT GRANT REVIEW FORM**

Grant Summary:		To provide people living in nursing facilities with the opportunity to live in the community with services and support as needed.			
Date:		5/19/2011			
Department:		AHS/DAIL			
Legal Title of Grant:		Vermont Money Follows the Person Project			
Federal Catalog #:		93.791			
Grant/Donor Name and Address:		USD HHS, CMC, 7500 Security Blvd, Mail Stop S2-26-12, Baltimore, MD 21244-1850			
Grant Period:		From:	To:		
		4/1/2011	3/31/2016		
Grant/Donation		\$ federal year 1			
	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	\$2,039,800	\$2,732,841	\$3,123,566	\$7,896,207	shown are for 3 years (+2 add'l years)
Position Information:		# Positions	Explanation/Comments		
		8	1 Admin Asst; 1 Nurse Case Mgr; 3 QM Specialists; 2 Data analysts		
Additional Comments:		This grant is for 5 years in total. Position are 100% federally funded and the 20% administrative costs are to be paid from state savings. If insufficient people choose to apply under this project, funds for the administrative costs may be in jeopardy.			
Department of Finance & Management		 05/19/11		(Initial) 	
Secretary of Administration				(Initial)	
Sent To Joint Fiscal Office				Date 6/1/11	

RECEIVED
 JUN 07 2011

JOINT FISCAL OFFICE

VERMONT GRANT ACCEPTANCE REQUEST Affordable Care Act (Form AA-1-ACA)		Priority Level (check one box): Expedited 14 Days <input type="checkbox"/> Normal 30 days <input checked="" type="checkbox"/>	
BASIC GRANT INFORMATION			
1. Agency:	Agency of Human Services		
2. Department:	Dept. of Disabilities, Aging and Independent Living		
3. Program:	Money Follows the Person (MFP)		
4. Legal Title of Grant:	Vermont Money Follows the Person Project		
5. Federal Catalog #:	93.791		
6. Grant/Donor Name and Address:			
US Dept of Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, Maryland 21244-1850			
7. Grant Period:	From:	4/1/2011	To: 3/31/2016
8. Purpose of Grant:			
<p>The purpose of the grant is to provide people living in nursing facilities the opportunity to live in the community with the services and supports they need. Over the next five years, it is anticipated that this grant will help approximately 375 adult Vermonters who have been living in a nursing facility for at least 90 days with VT Medicaid payment, and wish to leave the nursing facility but have been unable to do so because of a barrier to living in the community.</p> <p>As stated by Donald berwick, M.D., of CMS, "The Money Follows the Person program is hugely important to improving the lives of Medicaid beneficiaries. This helps bring everyone, even those who in the past may have had no choice but to live in an institution, into the community where they can become full participants in the activities most of us take for granted."</p> <p>The grant will provide:</p> <ul style="list-style-type: none"> - One-time funds (up to \$2500 per person) to help people transition from the nursing facility to the community; - Focused support from Transition Coordinator staff to help create successful care plans and transitions to the community with appropriate housing arrangements; - Enhanced federal match rate for the community-based services provided through the Choices for Care program during the first year after the person has transitioned to the community; - The development of a new Adult Family Care option as a new qualified home and community-based long-term care setting under the Choices for Care program; - Jobs for eight state and two contracted MFP positions, 100% federally funded. 			
9. Impact on existing program if grant is not Accepted:			
<p>If the grant is not accepted:</p> <ul style="list-style-type: none"> - An estimated 375 people over the next five years who are living in nursing facilities would lose the opportunity to transition to the community with the supports they need. - Vermont would lose approximately \$17.9 million dollars in additional federal grant money to support people living in the community. - The current Choices for Care program would lose the opportunity for an enhanced federal Medicaid match rate for the estimated 375 people that would be served by this grant over the next five years. - The Choices for Care program would be forced to continue paying for the estimated 375 people in nursing facility settings (instead of in the community), which would likely cost the state more to support. - The Choices for Care program would lose the opportunity to fund the development of a new home-based option called "Adult Family Care". - Vermont would lose the opportunity to provide jobs for an estimated eight state and two contractual people, 100% federally funded. 			

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
	FY 2012	FY 2013	FY 2014	
Expenditures:				
Personal Services	\$612,422	\$622,757	\$652,679	
Operating Expenses	\$182,950	\$111,525	\$112,025	
Grants	\$1,578,063	\$2,536,564	\$2,993,860	DVHA - CFC
Total	\$2,373,435	\$3,270,846	\$3,758,564	
Revenues:				
State Funds:				
Cash	\$333,635	\$538,005	\$634,998	
In-Kind	\$0	\$0	\$0	
Federal Funds:				
(Direct Costs)	\$2,039,800	\$2,732,841	\$3,123,566	
(Statewide Indirect)	\$2,002,187	\$2,698,160	\$3,087,461	
(Departmental Indirect)	\$22,568	\$20,809	\$21,663	
	\$15,045	\$13,872	\$14,442	
Other Funds:				
Grant (source)	\$	\$	\$	
Total	\$2,373,435	\$3,270,846	\$3,758,564	

Appropriation No:	Amount:	\$
3460010000		\$795,372
3410016000		\$1,578,063
		\$
		\$
		\$
		\$
		\$
	Total	\$2,373,435

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? Yes No
 If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Susan Wehry, M.D. Agreed by: *SW* (initial)

12. Limited Service Position Information:	# Positions	Title
	2	Program Director & Admin. Assistant (half-time position)
	3	Transition Coordinators
	2	Quality Management Specialists
	1	Data Analyst
Total Positions	8	

12a. Equipment and space for these positions: Is presently available. Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless	Signature: <u><i>Susan Wehry</i></u>	Date: <u>5/6/11</u>
	Title: <u>Commissioner, DASH</u>	
	Signature: <u><i>Patrick F. Corl</i></u>	Date: <u>5/13/11</u>

previous notification was made on Form AA-1PN (if applicable):

Title: Deputy Secretary AHS

14. SECRETARY OF ADMINISTRATION

<input checked="" type="checkbox"/> Approved:	(Secretary or designee signature) <i>[Signature]</i> Deputy	Date: 05/19/11
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15. ACTION BY GOVERNOR

<input checked="" type="checkbox"/> Check One Box: Accepted	(Governor's signature) <i>[Signature]</i>	Date: 5/31/11
<input type="checkbox"/> Rejected		

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

<input checked="" type="checkbox"/> Request Memo	<input type="checkbox"/> Notice of Donation (if any)
<input type="checkbox"/> Dept. project approval (if applicable)	<input checked="" type="checkbox"/> Grant (Project) Timeline (if applicable)
<input checked="" type="checkbox"/> Notice of Award	<input type="checkbox"/> Request for Extension (if applicable)
<input checked="" type="checkbox"/> Grant Agreement	<input type="checkbox"/> Form AA-1PN attached (if applicable)
<input checked="" type="checkbox"/> Grant Budget	

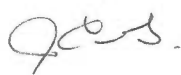
End Form AA-1

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Agency of Human Services
Business Office
103 South Main Street
Waterbury, VT 05671-0204
[phone] 802-241-2949
[fax] 802-241-1200

MEMORANDUM

TO: Money Follows the Person Reviewers

FROM: Jim Giffin, AHS CFO 

DATE: May 9, 2011

RE: MFP AA-1

DATZ
received
5/18/11
Map

This grant application contains a significant amount of back up material that we have organized.

The federally approved grant had some obvious financial calculation flaws that we have adjusted for with the AA-1 to have the projected expenses reflect the expected expenditures for year one and subsequent years.

The grant package includes 8 positions and cost approximately \$750,000/yr for personal services and operating expenses. The staff is 100% federally funded, with the federal guidance trying to maintain the administrative expenses at 20% of the program expenses. The grant provides enhanced FMAP to the State for each person's home and community based services for the *first twelve months* from the day they leave the nursing home.

There are significant information technology issues, program, and financial reporting issues with this grant. DAIL has agreed to collect the required information manually from the MMIS and other sources, before we attempt to implement expensive and staff time consuming changes across departments. Additional and different program and IT changes will be necessary if the State chooses to pursue a 'DUAL's waiver after the completion of the DUAL's planning contract twelve months from now.

The largest unknown in this grant is the number of people who will choose to apply and will be successfully placed. One of the main eligibility requirements is having a 90 consecutive *Medicaid* nursing home stay. A feasibility analysis conducted in November 2010 estimated there were approximately 100 people who meet the MFP criteria *and* want to move. The grant assumes DDAIL can move 70-80 people per year. I think there is an open question on whether this amount of people will choose to move and if the CFC/MFP service package will cover all items necessary for a successful move. The feasibility did not address that after you take out 100% of the MFP eligible people who want to move by year two, if they will be replaced by new eligible people.

I estimate the value of the enhanced FMAP to the State somewhere between \$300,000 and \$600,000 per year depending on the assumptions you use for people served and inflation. The DDAIL federally covered cost of administration is estimated at \$750k/yr and does not include cost for DVHA, DCF, AHS CO time or time of community providers (nursing homes, AAA, HHA staff) spent implementing the grant.

REC'D MAY 18 2011

Money Follows the Person

Calculation of the Enhanced match rate savings based on estimated expenses (cash basis) on Plan's of Care

Current Plan of Care Average for H&CB (all categories including moderate) (as of 5/3/11 data) Avg. of Cash Expense March 2011	\$ 27,360
(all categories including moderate)	\$ 20,808
Utilization of Plan on Cash Basis	76.1%

Current (5-1-11 data) Plan of Care Average for HCBS (not including MNG, PACE, ERC, FC)	\$ 39,672
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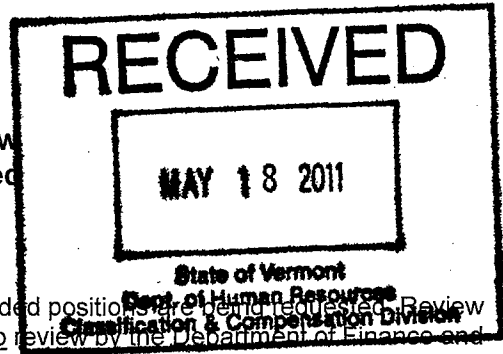
Estimated Plan of Care costs with inflation factor of 7.28% starting in CY12)	Annual POC	Estimated MFP People Served each year	CY cost	Utilization of Plan on Cash Basis 80% Estimate	Regular Match Rate 58.71% thru 9/30/11 and 57.58 there after	Enhanced Match Rate (CY11 QE 9/11 79.355%) (CY11 QE 12/11 thru CY16 78.79%)	Amount available for Rebalancing due to Enhanced Match Rate
Estimated Plan of Care MFP in CY11 (QE 9/11)	\$ 39,541	12	\$ 237,246	\$ 189,797	\$ 111,430	\$ 150,613	\$ 39,184
Estimated Plan of Care MFP in CY11 (QE 12/11)	\$ 39,541	13	\$ 257,017	\$ 205,613	\$ 118,392	\$ 162,003	\$ 43,611
Estimated Plan of Care MFP in CY12	\$ 42,238	70	\$ 2,956,631	\$ 2,365,305	\$ 1,361,942	\$ 1,863,624	\$ 501,681
Estimated Plan of Care MFP in CY13	\$ 45,130	75	\$ 3,384,779	\$ 2,707,823	\$ 1,559,165	\$ 2,133,494	\$ 574,329
Estimated Plan of Care MFP in CY14	\$ 48,234	85	\$ 4,099,872	\$ 3,279,897	\$ 1,888,565	\$ 2,584,231	\$ 695,666
Estimated Plan of Care MFP in CY15	\$ 51,563	90	\$ 4,640,680	\$ 3,712,544	\$ 2,137,683	\$ 2,925,114	\$ 787,431
Estimated Plan of Care MFP in CY16	\$ 55,135	30	\$ 1,654,047	\$ 1,323,237	\$ 761,920	\$ 1,042,579	\$ 280,659
(Estimated POC includes \$2,500 for Demonstration in all years)	\$ 321,382	375	\$ 17,230,271	\$ 13,784,217	\$ 7,939,097	\$ 10,861,657	\$ 2,922,560

Estimated Plan of Care costs with no inflation factor)	Annual POC	Estimated MFP People Served each year	CY cost	Utilization of Plan on Cash Basis 80% Estimate	Regular Match Rate 58.71% thru 9/30/11 and 57.58 there after	Enhanced Match Rate (CY11 QE 9/11 79.355%) (CY11 QE 12/11 thru CY16 78.79%)	Amount available for Rebalancing due to Enhanced Match Rate
Estimated Plan of Care MFP in CY11 (QE 9/11)	\$ 39,541	12	\$ 237,246	\$ 189,797	\$ 111,430	\$ 150,613	\$ 39,184
Estimated Plan of Care MFP in CY11 (QE 12/11)	\$ 39,541	13	\$ 257,017	\$ 205,613	\$ 118,392	\$ 162,003	\$ 43,611
Estimated Plan of Care MFP in CY12	\$ 39,541	70	\$ 2,767,870	\$ 2,214,296	\$ 1,274,992	\$ 1,744,644	\$ 469,652
Estimated Plan of Care MFP in CY13	\$ 39,541	75	\$ 2,965,575	\$ 2,372,460	\$ 1,366,062	\$ 1,869,261	\$ 503,199
Estimated Plan of Care MFP in CY14	\$ 39,541	85	\$ 3,360,985	\$ 2,688,788	\$ 1,548,204	\$ 2,118,496	\$ 570,292
Estimated Plan of Care MFP in CY15	\$ 39,541	90	\$ 3,558,690	\$ 2,846,952	\$ 1,639,275	\$ 2,243,113	\$ 603,839
Estimated Plan of Care MFP in CY16	\$ 39,541	30	\$ 1,186,230	\$ 948,984	\$ 546,425	\$ 747,704	\$ 201,280
(Estimated POC includes \$2,500 for Demonstration in all years)	\$ 276,787	375	\$ 14,333,613	\$ 11,466,890	\$ 6,604,780	\$ 9,035,835	\$ 2,431,055

Estimated Plan of Care costs with no inflation factor)	Annual POC	Estimated MFP People Served each year	CY cost	Utilization of Plan on Cash Basis 80% Estimate	Regular Match Rate 58.71% thru 9/30/11 and 57.58 there after	Enhanced Match Rate (CY11 QE 9/11 79.355%) (CY11 QE 12/11 thru CY16 78.79%)	Amount available for Rebalancing due to Enhanced Match Rate
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Estimated Plan of Care MFP in CY11 (QE 12/11)	\$ 39,541	13	\$ 257,017	\$ 205,613	\$ 118,392	\$ 162,003	\$ 43,611
Estimated Plan of Care MFP in CY12	\$ 39,541	50	\$ 1,977,050	\$ 1,581,640	\$ 910,708	\$ 1,246,174	\$ 335,466
Estimated Plan of Care MFP in CY13	\$ 39,541	50	\$ 1,977,050	\$ 1,581,640	\$ 910,708	\$ 1,246,174	\$ 335,466
Estimated Plan of Care MFP in CY14	\$ 39,541	50	\$ 1,977,050	\$ 1,581,640	\$ 910,708	\$ 1,246,174	\$ 335,466
Estimated Plan of Care MFP in CY15	\$ 39,541	50	\$ 1,977,050	\$ 1,581,640	\$ 910,708	\$ 1,246,174	\$ 335,466
Estimated Plan of Care MFP in CY16	\$ 39,541	30	\$ 1,186,230	\$ 948,984	\$ 546,425	\$ 747,704	\$ 201,280
(Estimated POC includes \$2,500 for Demonstration in all years)	\$ 276,787	255	\$ 9,588,693	\$ 7,670,954	\$ 4,419,080	\$ 6,045,017	\$ 1,625,937

* if only 255

**STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form**



This form is to be used by agencies and departments when additional grant funded positions are being requested and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report must be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/DAIL Date: 4/8/11

Name and Phone (of the person completing this request): Megan Tierney-Ward 241-2426

Request is for:

- Positions funded and attached to a new grant.
- Positions funded and attached to an existing grant approved by JFO # _____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

US Dept. of Health & Human Services, Centers for Medicare and Medicaid Services
"Money Follows the Person Demonstration Grant"
Cat No. #93.791

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

<u>Title* of Position(s) Requested</u>	<u># of Positions</u>	<u>Division/Program</u>	<u>Grant Funding Period/Anticipated End Date</u>
Project Director = 1, Administrative Assistant = 1, Nurse Case Manager (aka Transition Coordinator) = 3, Quality Management Specialist = 2, Aging and Disabilities System Developer (aka Data Analyst) = 1.			

All positions will be in DAIL/DDAS. Grant period is 4/1/11-3/31/16 for all positions. They are 100% federally funded.

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

The purpose of the grant is to provide people living in nursing facilities the opportunity to live in the community with the services and supports they need. Over the next five years, it is anticipated that this grant will help approximately 375 adult Vermonters who have been living in a nursing facility for at least 90 days with VT Medicaid payment, and wish to leave the nursing facility but have been unable to do so because of a barrier to living in the community.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b)).

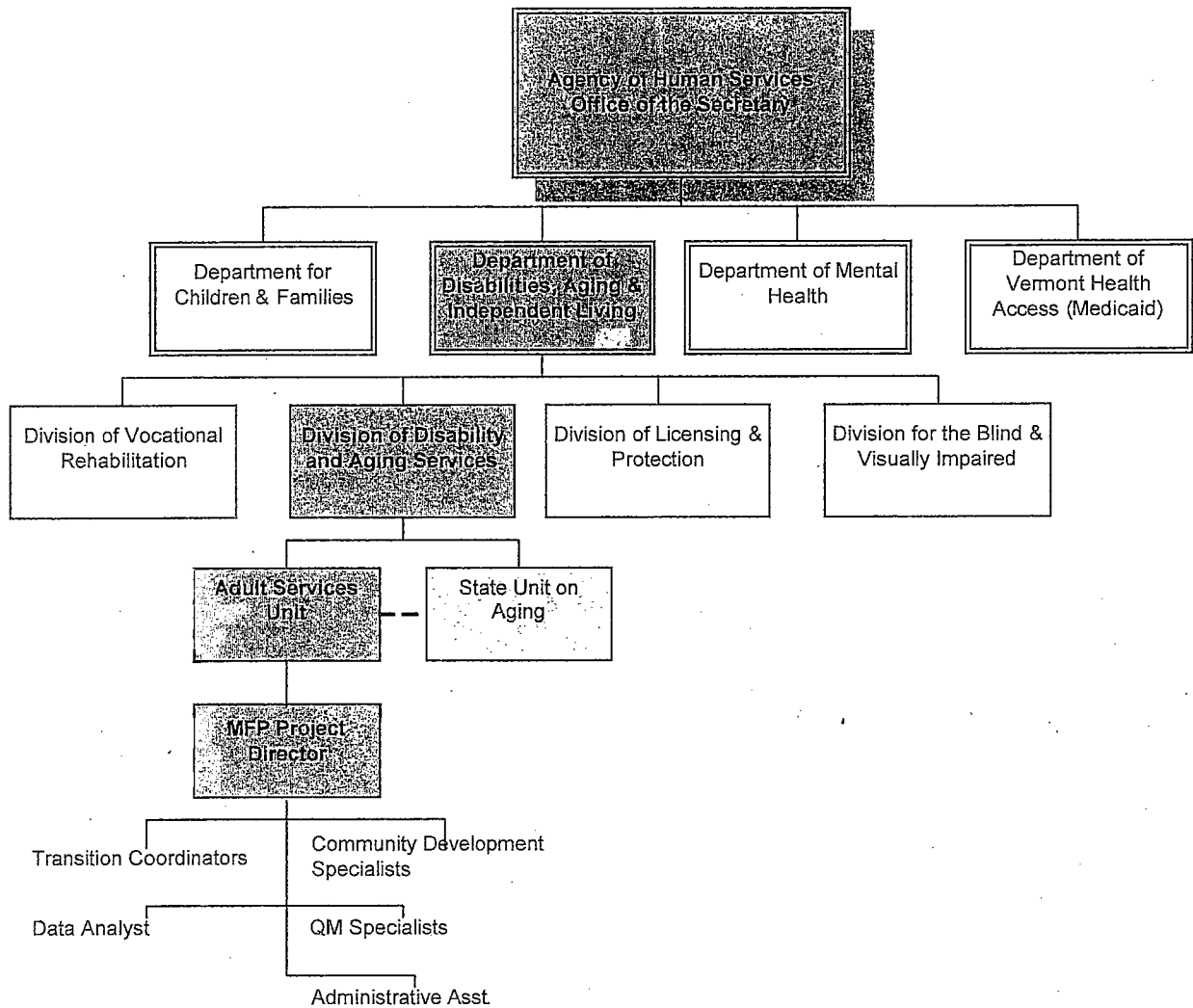
Susan Webster 4/11/11
Signature of Agency or Department Head Date

Molly Paulk 5/18/11
Approved/Denied by Department of Human Resources Date

Susan Bell 5/19/11
Approved/Denied by Finance and Management Date

[Signature] 5/19/11
Approved/Denied by Secretary of Administration Date

Comments:



Wage and Fringe Calculations for the Money Follows the Person Grant for 5 Grant years

Positions needed for the MFP Application (7.5 positions)

- 1 FTE Project Director (PG 25)
- .5 FTE Admin Assistant B (PG 19)
- 3 Transition Coordinators (PG24)
- 2 Quality Staff (divided up between DLP & DDAS - PG 24)
- 1 Planner/Data Analyst (in the DPU - PG 24)

	Used for Year 1 and 2		Used for Year 3		Used for Year 4		Used for year 5		Used for year 6	
	2011-2012	Year 1-Step 2	2012-2013	Year 2-Step 2	2013-2014	Year 3-Step 3	2014-2015	Year 4-Step 4	2015-2016	Year 5-Step 5
		23.08		23.79		25.09		25.88		27.17
		16.48		16.99		17.86		18.44		19.35
		21.79		22.46		23.62		24.39		25.59
		21.79		22.46		23.62		24.39		25.59
		21.79		22.46		23.62		24.39		25.59

Average fringe for the whole dept was 43.75%. Yellow items have been adjusted downward to make total % agree with the Department average fringe %

Grant period is April 1, 2011 - March 31, 2016

Total for all 5 Grant years: Grant runs over 6 SFYs however there will be no expenditures until July 1, 2011

(Individual years shown below)

	1 FTE Proj. Director	.5 FTE Admin B	(3) 1 FTE Transition Coordinators	(2) 1 FTE Quality Staff (Divided between DLP & DDAS)	1 FTE Planner/Data Analyst (in the DPU)	Total of All Positions for 6 SFYs (5 grant yrs)
	6 Year Wages & Fringe	6 Year Wages & Fringe	6 Year Wages & Fringe	6 Year Wages & Fringe	6 Year Wages & Fringe	Total 6 year wages below
Benefits as adj. to agree w/Dept. total ave. fringe %	245,915.75	87,658.78	695,464.17	463,642.78	231,821.39	1,724,502.85
State Share EAP	122.96	43.83	347.73	231.82	115.81	865.25
State Share Dental	3,120.67	1,112.39	8,825.44	5,883.63	2,941.81	21,883.94
State Share Health	45,617.37	16,260.70	129,008.60	86,005.74	43,002.87	319,895.28
State Share Life	1,059.90	377.81	2,997.45	1,998.30	999.15	7,432.61
State Share Retirement	38,854.69	13,850.08	109,883.34	73,255.58	36,627.78	272,471.45
State Share FICA	88,775.58	31,644.81	251,062.57	167,375.04	83,687.52	622,545.53
Total Fringe	18,812.55	6,705.90	53,203.01	35,468.67	17,734.34	131,924.47
Total Wages & Fringe	107,588.14	38,350.71	304,265.58	202,843.72	101,421.86	754,470.00
	353,303.89	126,009.47	999,729.75	666,486.50	333,243.25	142,701.60
check	107,588.14	38,350.71	304,265.58	202,843.72	101,421.86	2,621,674.45
						754,470.00
						2,478,972.85
						2,478,972.85

Year 1 / End of SFY11 / May & June 2011 - no salary and fringe

	1 FTE Proj. Director	.5 FTE Admin B	(3) 1 FTE Transition Coordinators	(2) 1 FTE Quality Staff (Divided between DLP & DDAS)	1 FTE Planner/Data Analyst (in the DPU)	Total of All Positions for Year 1
	Year 1 - Wages & Fringe	Year 1 - Wages & Fringe	Year 1 - Wages & Fringe	Year 1 - Wages & Fringe	Year 1 - Wages & Fringe	Total Year 1 - Wages & Fringe
Benefits as adj. to agree w/Dept. total ave. fringe %	0.00	0.00	0.00	0.00	0.00	0.00
State Share EAP	0.00	0.00	0.00	0.00	0.00	0.00
State Share Dental	0.00	0.00	0.00	0.00	0.00	0.00
State Share Health	0.00	0.00	0.00	0.00	0.00	0.00
State Share Life	0.00	0.00	0.00	0.00	0.00	0.00
State Share Retirement	0.00	0.00	0.00	0.00	0.00	0.00
State Share FICA	0.00	0.00	0.00	0.00	0.00	0.00
Total Fringe	0.00	0.00	0.00	0.00	0.00	0.00
Total Wages & Fringe	0.00	0.00	0.00	0.00	0.00	0.00
check	0.00	0.00	0.00	0.00	0.00	0.00

Year 2 / SFY12

	1 FTE Proj. Director	.5 FTE Admin B	(3) 1 FTE Transition Coordinators	(2) 1 FTE Quality Staff (Divided between DLP & DDAS)	1 FTE Planner/Data Analyst (in the DPU)	Total of All Positions for Year 2
	Year 2 - Wages & Fringe	Year 2 - Wages & Fringe	Year 2 - Wages & Fringe	Year 2 - Wages & Fringe	Year 2 - Wages & Fringe	Total Year 2 - Wages & Fringe
Benefits as adj. to agree w/Dept. total ave. fringe %	48,006.40	17,139.20	135,969.60	90,846.40	45,323.20	337,284.80
State Share EAP	24.00	8.57	67.98	45.32	22.66	168.54
State Share Dental	609.20	217.50	1,725.45	1,150.30	575.15	4,277.61
State Share Health	8,905.19	3,179.32	25,222.36	16,814.91	8,407.45	62,529.23
State Share Life	206.91	73.87	588.03	390.69	195.34	1,452.84
State Share Retirement	7,585.01	2,707.99	21,483.20	14,322.13	7,161.07	53,259.40
State Share FICA	17,330.31	6,187.25	49,088.03	32,723.35	16,361.68	121,687.61
Total Fringe	3,672.49	1,311.15	10,401.67	6,934.45	3,467.22	25,786.99
Total Wages & Fringe	68,008.20	24,637.80	195,456.30	130,304.20	65,152.10	484,559.40
check	68,008.20	24,637.80	195,456.30	130,304.20	65,152.10	484,559.40

Year 3 / SFY13

	1 FTE Proj. Director	.5 FTE Admin B	(3) 1 FTE Transition Coordinators	(2) 1 FTE Quality Staff (Divided between DLP & DDAS)	1 FTE Planner/Data Analyst (in the DPU)	Total of All Positions for Year 3
	Year 3 - Wages & Fringe	Year 3 - Wages & Fringe	Year 3 - Wages & Fringe	Year 3 - Wages & Fringe	Year 3 - Wages & Fringe	Total Year 3 - Wages & Fringe
Benefits as adj. to agree w/Dept. total ave. fringe %	49,483.20	17,689.60	140,150.40	93,433.60	46,716.80	347,453.60
State Share EAP	24.74	8.83	70.08	46.72	23.36	173.73
State Share Dental	627.94	224.23	1,778.51	1,185.67	592.84	4,409.19
State Share Health	9,179.13	3,277.71	25,997.90	17,331.93	8,665.97	64,452.64
State Share Life	213.27	76.16	604.05	402.70	201.35	1,497.53
State Share Retirement	7,818.35	2,791.80	22,143.76	14,782.51	7,381.25	54,897.67
State Share FICA	17,863.44	6,378.73	50,905.29	33,729.53	16,864.76	125,430.75
Total Fringe	3,785.46	1,351.72	10,721.51	7,147.67	3,573.84	26,580.20
Total Wages & Fringe	21,648.90	7,730.45	61,315.80	40,877.20	20,438.60	152,010.95
check	21,648.90	7,730.45	61,315.80	40,877.20	20,438.60	152,010.95

Year 4 / SFY14

	1 FTE Proj. Director	.5 FTE Admin B	(3) 1 FTE Transition Coordinators	(2) 1 FTE Quality Staff (Divided between DLP & DDAS)	1 FTE Planner/Data Analyst (in the DPU)	Total of All Positions for Year 4
	Year 4 - Wages & Fringe	Year 4 - Wages & Fringe	Year 4 - Wages & Fringe	Year 4 - Wages & Fringe	Year 4 - Wages & Fringe	Total Year 4 - Wages & Fringe
Benefits as adj. to agree w/Dept. total ave. fringe %	52,188.83	18,578.56	147,382.87	98,235.25	49,127.82	365,533.17
State Share EAP	26.09	9.29	73.69	49.13	24.56	192.77
State Share Dental	682.28	235.76	1,870.29	1,246.86	623.43	4,638.82
State Share Health	9,681.03	3,446.32	27,339.52	18,226.35	9,113.17	67,806.40
State Share Life	224.93	80.07	635.22	423.48	211.74	1,575.45
State Share Retirement	8,245.84	2,935.41	23,286.49	15,524.33	7,762.16	57,754.24
State Share FICA	18,840.18	6,706.86	53,205.22	35,470.14	17,735.07	131,957.47
Total Fringe	3,392.45	1,421.26	11,274.79	7,516.53	3,758.26	27,963.29
Total Wages & Fringe	22,832.83	8,128.12	64,480.01	42,988.67	21,493.34	159,920.76
check	22,832.83	8,128.12	64,480.01	42,988.67	21,493.34	159,920.76

Year 5 / SFY15

	1 FTE Proj. Director Year 5 - Wages & Fringe	.5 FTE Admin B Year 5 - Wages & Fringe	(3) 1 FTE Transition Coordinators Year 5 - Wages & Fringe	(2) 1 FTE Quality Staff (Divided between DLP & DDAS) Year 5 - Wages & Fringe	1 FTE Planner/Data Analyst (in the DPUJ) Year 5 - Wages & Fringe	Total of All Positions for Year 5 Total Year 5 - Wages & Fringe
Benefits as adl. to agree w/Dept. total ave. fringe %	53,856.71	19,180.25	152,196.41	101,464.27	50,732.14	377,429.78
State Share EAP	26.93	9.59	76.10	50.73	25.37	188.71
State Share Dental	663.44	243.40	1,931.37	1,287.58	643.79	4,789.58
State Share Health	9,990.42	3,557.94	28,232.43	18,821.62	9,410.81	70,013.22
State Share Life	232.12	82.67	655.97	437.31	218.66	1,526.72
State Share Retirement	15,800.00	8,509.36	3,030.48	24,047.03	16,031.35	59,833.91
State Share FICA	19,442.27	6,824.07	54,942.90	36,628.60	18,314.30	136,252.15
Total Fringe	4,120.04	1,467.29	11,643.03	7,762.02	3,881.01	28,873.38
Total Wages & Fringe	77,419.02	27,571.61	218,782.34	145,854.89	72,927.45	542,555.31
check	23,562.31	8,391.36	66,585.93	44,390.62	22,195.31	165,125.53

Year 6 / Part of SFY16 / July 2015-March 2016 / 1,560 hours

	1 FTE Proj. Director Year 6 - Wages & Fringe	.5 FTE Admin B Year 6 - Wages & Fringe	(3) 1 FTE Transition Coordinators Year 6 - Wages & Fringe	(2) 1 FTE Quality Staff (Divided between DLP & DDAS) Year 6 - Wages & Fringe	1 FTE Planner/Data Analyst (in the DPUJ) Year 6 - Wages & Fringe	Total of All Positions for Year 6 Total Year 6 - Wages & Fringe
Benefits as adl. to agree w/Dept. total ave. fringe %	42,380.57	15,091.15	119,764.89	79,843.26	39,821.63	439,702.10
State Share EAP	21.19	7.55	59.88	39.92	19.96	148.50
State Share Dental	537.81	191.51	1,519.82	1,013.21	506.61	3,768.95
State Share Health	7,861.60	2,799.41	22,216.39	14,810.93	7,405.46	55,093.78
State Share Life	182.66	65.04	516.19	344.12	172.06	1,280.08
State Share Retirement	6,595.13	2,394.40	18,922.85	12,815.24	6,307.82	46,926.24
State Share FICA	15,299.39	5,447.91	43,235.13	28,823.42	14,411.71	107,217.54
Total Fringe	3,242.11	1,154.47	9,162.01	6,108.01	3,054.90	22,720.62
Total Wages & Fringe	60,922.07	21,693.54	172,162.03	114,774.69	57,387.34	566,640.27
check	18,541.50	6,298.98	53,367.14	34,931.43	17,465.71	192,289.67

Money Follows the Person
Budget for the Six (6) State Fiscal Years (Actually Five Grant Award Years April 1, 2011 through March 31, 2016)

Budget for JFO Expenditures	SFY 1 SFY2011	SFY 2 SFY2012	SFY 3 SFY2013	SFY 4 SFY2014	SFY 5 SFY2015	SFY 6 SFY2016	Total
Admin (100% Federal):							
Personnel & Fringe Contractual	0	484,559	499,465	525,454	542,555	569,641	2,621,675
	0	98,700	93,636	96,145	98,730	75,705	462,916
Subtotal Personal Svcs	0	583,259	593,101	621,599	641,285	645,346	3,084,591
Operating Expenses	0	169,000	100,500	100,500	100,500	100,500	571,000
Subtotal P/S & O/E Directs	0	752,259	693,601	722,099	741,785	745,846	3,655,591
Personal Services Indirects	0	29,163	29,656	31,080	32,064	32,267	154,230
Operating Expenses Indirects	0	8,450	5,025	5,025	5,025	5,025	28,550
Subtotal Indirects	0	37,613	34,681	36,105	37,089	37,292	182,780
Total P/S Dir. & Indir.	0	612,422	622,757	652,679	673,349	677,615	3,238,821
Total O/E Dir & Indir.	0	177,450	105,525	105,525	105,525	105,525	599,550
Total P/S & O/E Dir. & Indir.	0	789,872	728,282	758,204	778,874	783,140	3,838,371
Fed. Eval. Supports (not in admin budget)	0	5,500	6,000	6,500	7,000	12,500	37,500
Grants - DVHA - CFC - Federal Share	0	1,244,428	1,998,559	2,358,862	2,754,672	2,505,135	10,861,656
Grants - DVHA - CFC - State Share	0	333,635	538,005	634,998	741,548	674,374	2,922,560
Total Grants	0	1,578,063	2,536,564	2,993,860	3,496,221	3,179,509	13,784,217
Total Costs	0	2,373,435	3,270,846	3,758,564	4,282,095	3,975,149	17,660,088

Grant Breakout between Federal and State 5/5/11							
MFP Enhanced FMAP rate - Fed FFY11 Q3 & Q4	79.3550%	79.3550%					
State Share	20.6450%	20.6450%					
MFP Enhanced FMAP rate - Fed FFY12 forward		78.7900%	78.7900%	78.7900%	78.7900%	78.7900%	
State Share		21.2100%	21.2100%	21.2100%	21.2100%	21.2100%	
ARRA MFP Enhanced FMAP rate-Fed	82.6200%						
State Share	17.3800%						
Total Grants	0	1,578,063	2,536,564	2,993,860	3,496,221	3,179,509	13,784,217
Grants - Federal Share @ 82.6200%	0	0	0	0	0	0	0
Grants - Federal Share @ 79.3550%	0	150,613	0	0	0	0	150,613
Grants - Federal Share @ 78.7900%	0	1,093,814	1,998,559	2,358,862	2,754,672	2,505,135	10,711,043
Grants - Federal Share Total	0	1,244,428	1,998,559	2,358,862	2,754,672	2,505,135	10,861,656
Grants - State Share @ 17.3800%	0	0	0	0	0	0	0
Grants - State Share @ 20.6450%	0	39,184	0	0	0	0	39,184
Grants - State Share @ 21.2100%	0	294,451	538,005	634,998	741,548	674,374	2,883,376
Grants - State Share Total	0	333,635	538,005	634,998	741,548	674,374	2,922,560
Total Grants	0	1,578,063	2,536,564	2,993,860	3,496,221	3,179,509	13,784,217

Info For AA-1 Form

For JFO form Expenditures:	SFY 1 SFY2011	SFY 2 SFY2012	SFY 3 SFY2013	SFY 4 SFY2014	SFY 5 SFY2015	SFY 6 SFY2016	Total
P/S	0	612,422	622,757	652,679	673,349	677,615	3,238,822
O/E	0	182,950	111,525	112,025	112,525	118,025	637,050
Grants	0	1,578,063	2,536,564	2,993,860	3,496,221	3,179,509	13,784,216
Total Expenditures	0	2,373,435	3,270,846	3,758,564	4,282,095	3,975,149	17,660,088
Revenues:							
State Funds:							
Cash	0	333,635	538,005	634,998	741,548	674,374	2,922,560
In-Kind	0	0	0	0	0	0	0
Total State Funds	0	333,635	538,005	634,998	741,548	674,374	2,922,560
Federal Funds:							
(Direct Costs)	0	2,002,187	2,698,160	3,087,461	3,503,457	3,263,481	14,554,746
(Statewide Indirect)	0	22,568	20,809	21,663	22,254	22,376	109,670
(Departmental Indirect)	0	15,045	13,872	14,442	14,836	14,917	73,112
Total Federal Funds	0	2,039,800	2,732,841	3,123,566	3,540,546	3,300,775	14,737,528
Other Funds:							
Grant (source)	0	0	0	0	0	0	0
Total Other Funds	0	0	0	0	0	0	0
Total Revenues	0	2,373,435	3,270,846	3,758,564	4,282,095	3,975,149	17,660,088



FAQ Sheet (Updated 3/31/11)
Money Follows the Person (MFP)

Programmatic		
#	Question	Answer
P1	When did VT receive the MFP award and how much is the award?	On 2/28/11 the Centers for Medicare and Medicaid Services (CMS) notified VT that it had been awarded a MFP grant for \$17,963,059 over the next five years.
P2	What is the grant timeline?	The MFP grant runs from 4/1/11-3/31/16 (five years).
P3	When can MFP services start?	<p>There are several steps before VT will be ready to provide MFP services to eligible people. They are:</p> <ol style="list-style-type: none"> 1. AHS must first receive approval from the Legislative Joint Fiscal Committee (JFC) to accept the grant award and hire the necessary staff. JFC has the authority to approve or deny acceptance of this award. This process may take several weeks. 2. VT must respond to the CMS VT Specific Terms and Conditions by 4/4/11 with a revised Operational Protocol and budget. Final approval from CMS should happen by the end of April. 3. After approval from both JFC and CMS, DAIL will hire the MFP Project Director and Administrative Assistant. 4. Then DAIL and the Project Director will hire the remaining MFP staff. 5. Once all MFP staff have been hired and trained, DAIL may start providing MFP services to eligible people. DAIL estimates that this will be no sooner than 6/1/11.
P4	MFP is going to help people transition into community settings other than their own home. How will this comply with state law about providing nursing care and fire safety? Will there need to be a change in Choices for Care (CFC)?	<p>Initially, all approved MFP community-based services will be provided in the standard Choices for Care (CFC) settings which include:</p> <ol style="list-style-type: none"> 1. Own home (house, apartment, mobile home) 2. Home of another (friend, family, private home) 3. Enhanced Residential Care (Level III & Assisted Living Residences) <p>The only new MFP requirement for these settings is that for group living arrangements such as Level III Residential Care, there must be <u>no more than four unrelated people</u> residing together. (This limit does not apply to Assisted Living due to the nature of the requirements.)</p> <p>The MFP Transition Coordinator, who is helping the person leave the nursing home, will be responsible for screening all potential living arrangement to make sure they meet the MFP and existing CFC requirements.</p>

FAQ Sheet (Updated 3/31/11)

Money Follows the Person (MFP)

		<p>When the grant develops the new “Adult Family Care” setting option, it will be developed so that it complies with existing laws regarding housing and fire safety. Once developed, this new setting will be incorporated into the CFC Operational Protocol as required by CMS.</p>
P5	What services will be “regular” and what services “supplemental”?	<p>All MFP home and community-based services, including the MFP demonstration services Transition Funds, are considered “regular”. VT did not request MFP “supplemental services”.</p>
P6	What is the requirement for on-going commitment from the State?	<p>All administrative costs funded 100% by CMS, and the “transitional funds” service will end when the grant ends 3/31/16. All MFP long-term care services (except transitional funds), including Adult Family Care, will be integrated with the Choices for Care (CFC) program so all CFC services to the individual will continue as they are today.</p>
P7	What are the MFP position needs?	<p>The MFP grant includes <u>7.5 FTE positions</u> which are 100% federally funded through 3/31/16. The positions include:</p> <ul style="list-style-type: none"> • Project Director (1) • Administrative Assistant (.5) • Transition Coordinators (3) • Data Analyst (1) • Quality Management Specialists (2) <p>The grant also includes funds for two Community Development contracted positions.</p>
P8	What are the MFP programmatic reporting requirements?	<p>As required by the CMS Programmatic Special Terms & Conditions, the state must submit semi-annual web-based reports on:</p> <ul style="list-style-type: none"> • Structure – implemented programmatic changes • Process – implemented strategies & procedures • Output – products of the MFP program • Outcomes – results of the MFP program <p><i>See CMS Terms & Conditions for details.</i></p>
P9	Where can I find out more about the Money Follows the Person grant?	<p>More information can be found at:</p> <ul style="list-style-type: none"> • CMS MFP website: http://www.cms.gov/CommunityServices/20_MFP.asp • MFP Technical Assistance website http://mfp-tac.com/ • DAIL website: http://www.dail.vermont.gov/dail-whats-new/money-follows-the-person-grant.

FAQ Sheet (Updated 3/31/11)
Money Follows the Person (MFP)

Financial		
#	Question	Answer
F1	The state must track approved MFP services for the enhanced FMAP rate since the enhanced rate is time limited to 365 days of specific services. How will this be done?	AHS, DAIL, DVHA and DCF will work with HP (Medicaid billing contractor) to create a system to identify MFP individuals starting the day they leave the nursing home and track the community-based Choices for Care the next 365 days for the enhanced FMAP. For example, the DCF ACCSS system can identify someone by CFC setting (NH/ERC/HB/PACE) using a "level of care" code in the long panel. The long panel also includes an effective date and highest paid CFC provider. This long panel status occurs as soon as DCF is notified of the change in setting. In addition, the HP claims system (MMIS) can identify all CFC community based services by revenue code. For MFP tracking, the ACCESS and MMIS/HP systems must be utilized to create a report that identifies a person who has been on CFC LTC Medicaid in the nursing home for more than 90 days and then discharged to a community-based CFC setting with community based service claims. Once the person goes to a MFP approved CFC community setting, all of the CFC services, (identified by revenue code), will have an enhanced rate for 365 days post discharge.
F2	Is the CMS required Quality of Life survey included in the MFP budget?	Yes. It can be found on the budget worksheet under "Federal Evaluation Supports", reimbursed at \$100 per survey. Total amount in the budget is \$37,500, 100% federally funded over the life of the grant.
F3	How will we create a system that meets the CMS financial reporting requirements as set forth in the CMS Terms and Conditions? (there are seven different reports)	The MFP Program Director will be responsible for developing a system that meets the CMS reporting requirements. This will require a coordinated effort between the Program Director, MFP Data Analyst, DAIL business office, AHS business office, HP, and DVHA. <i>See #F14 for a list of financial reports.</i>
F4	What is the requirement for state matching funds?	<ul style="list-style-type: none"> • MFP provides 100% federal funding for all administrative grant costs. • MFP provides an enhanced federal Medicaid match for the already available Choice for Care services that MFP participants use for 365 days after discharge from the nursing facility. The enhanced federal rate reduces the state's share of those services from about 42% down to approximately 21% over the next five years. • MFP offers one-time "transitional funds" (aka

FAQ Sheet (Updated 3/31/11)
Money Follows the Person (MFP)

		<p>Demonstration HCBS) to MFP participants at \$2500 each. The state's total share for this service will be approximately <u>\$187,044 over five years</u>. The total federal match for this service is approximately \$698,368. This service is only available to qualified MFP participants and will end when the grant ends 3/31/16.</p> <p><i>See MFP budget worksheet for more detail.</i></p>
F5	<p>How will this grant affect the state's financial obligation for retirement benefits for the MFP positions?</p>	<p>Individuals employed by the State of Vermont must be employed <u>a minimum of five years</u> to be vested in the state retirement system. The individuals hired into the MFP positions will be employed for less than five years and will therefore not be fully vested into the state retirement system unless they were previously employed by the state or continue with other state employment after the end of the grant. Individuals who leave state employment prior to five years will receive their retirement contribution plus interest.</p>
F6	<p>Is there a cap on administrative costs?</p>	<p>Yes. Administrative costs are capped at 20% of the total federal portion of the grant. VT was not aware of this cap because it was not in the RFP. After CMS granted VT the MFP award, CMS confirmed that it was not in the application RFP, but is a CMS "guidance" generally used during their grant application and budget building process. Once the program begins, CMS expects that the 1st year administrative costs will likely be "front loaded" which may make them higher than 20% due to start-up related costs. Ongoing, if the admin costs exceed 20%, CMS will work with the state to determine the reason why admin costs are high and whether program changes need to occur. States may request an admin cap higher than 20%, which CMS may approve or deny.</p> <p>NOTE: CMS will NOT 1) terminate the grant for being over 20% admin and 2) will NOT deny payment for admin costs that exceed 20%.</p>
F7	<p>Was VT required to make changes to the MFP budget after the grant was awarded by CMS?</p>	<p>Yes.</p> <ul style="list-style-type: none"> • VT was required to reduce the administrative budget to approximately 20% of the total federal budget. This necessitated removing the Transition Consultant contracts (\$1.3 million) in addition to prorating the 1st and last year of the other contracted services in the budget. The total changes reduced the administrative budget by approximately \$1.4 million. • VT corrected the enhanced FMAP rates in the

FAQ Sheet (Updated 3/31/11)

Money Follows the Person (MFP)

		<p>budget worksheet due to a misunderstanding of the CMS worksheet instructions. The correction increased the HCBS budget by approximately \$848,000.</p> <ul style="list-style-type: none"> • Due to a delay in starting MFP services, the CY11 budget was revised to exclude estimated HBCS for April and May. This reduced the CY11 budget by approximately \$460,000.
F8	Should states report the total gross expenditures on the MFP application MOE (Maintenance of Effort) form, or just the state's share of the total expenditures?	The <u>state's share</u> of the total expenditures is reported on the MFP application MOE. The state must re-submit the MFP MOE annually by January 31.
F9	May the state choose to report expenditures on the MOE form using the state fiscal year?	Yes.
F10	As a requirement of the MFP demonstration grant, the state must complete a new MOE each year and submit to CMS by January 31 st . What happens if the reported expenditures go down?	CMS has confirmed that the goal of the MOE is for total state share expenditures to remain the same or increase over the period of the grant. If the total state share expenditures on the MOE form <u>go down</u> , CMS will request an explanation from the state. They understand that most states are facing budget issues which may affect the total expenditures. CMS will NOT terminate the grant or deny funding if the MOE reported expenditures goes down.
F11	Vermont made corrections to the enhanced FMAP that was used to create the application budget. This correction increased the total HCBS budget. Will this affect the CMS total grant award?	No. The grant award remains at \$17,963,059. However, as described in the CMS Programmatic Special Terms & Conditions, VT may request a "supplemental award" later if needed.
F12	What happens if VT spends less money than anticipated?	CMS will review the reasons why less money was spent and see if any programmatic changes need to be made. Unspent funds will be carried over into the next calendar year.
F13	What happens if VT serves more people than expected and requires additional MFP funds to meet the need?	As described in the CMS Programmatic Special Terms & Conditions, VT may request a "supplemental award" each year as necessary.
F14	What are the MFP financial reporting requirements?	<p>As required by the CMS Programmatic Special Terms & Conditions, the state must submit:</p> <ul style="list-style-type: none"> • CMS 64.9i, 9Pi, and 64.10i, 10Pi – track expenditures (quarterly) • MFP Program Files – track enrollment, quality of life & Medicaid claims records (quarterly) • MFP Financial Reporting Forms A, B, C, & D – modified from CMS 64, tracking qualified MFP expenditures (quarterly) • Federal Financial Report SF-425 – financial status report (semi-annually) • Payment Management System (PMS) Smartlink

FAQ Sheet (Updated 3/31/11)
Money Follows the Person (MFP)

		<p>SF-425 – aggregate accounting of grantee’s to pay for demonstration expenditures and report aggregate expenditures. (quarterly)</p> <ul style="list-style-type: none">• Maintenance of Effort (MOE) form – captures the state share of all LTC expenditures (community & institutional) to ensure the State has maintained its financial effort taking into account all service costs, admin costs and rebalancing investments. (annually by Jan 31st)• MFP Worksheet for Proposed Budget – standardized report of high level budget info and projected transition benchmark info. (annually by Jan 31st) <p><i>See CMS Terms & Conditions for details.</i></p>
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MAR 10 2011
VT DAIL
Commissioner's Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP, and Survey & Certification

FEB 25 2011

Ms. Camille George
Deputy Commissioner
Vermont Department of Disabilities, Aging and Independent Living
103 South Main Street
Weeks Building
Waterbury, VT 05671-1601

Dear Ms. George:

I am pleased to inform you that Vermont has been awarded a 2011 Money Follows the Person Rebalancing Demonstration Grant. Congratulations on your successful application!

We, at the Centers for Medicare & Medicaid Services (CMS), thank you for your efforts in preparing the application and look forward to our work together throughout the grant period. We are positive this demonstration grant will greatly enhance your efforts to rebalance your long-term support system so that individuals have a choice of where they live and receive services. In addition to enhancing your efforts to design and implement rebalancing initiatives, this demonstration grant will also allow you to adopt strategic approaches for improving quality in home and community-based services.

The Period of Performance for this grant award is April 1, 2011 through March 31, 2016. Your first year award is in the amount of \$2,123,975. Your projected award through 2016 of \$17,963,059 will be awarded in successive fiscal years as supplemental grant awards, dependent on the annual attainment of your two required rebalancing benchmarks and your funding needs for the subsequent calendar year. When your program exceeds your transition benchmark and serves more participants or you add additional services, additional supplemental funding will be provided.

Use of MFP award funding for the provision of services is restricted until your Operational Protocol is approved by your CMS Project Officer. However, you may begin to draw down and expend administrative funding from the grant award for building your demonstration infrastructure and hiring staff as indicated in your grant budget narrative and your grant specific terms and conditions. By drawing grant funds from your account, you have accepted the terms and conditions of this grant award.

Please closely examine this offer including the attached terms and conditions. In addition to the general terms and conditions, this grant award contains programmatic and grant specific terms and conditions that you will need to review. A call will be scheduled with your assigned CMS

Page 2 - Ms. Camille George

Project Officer to discuss the details of your award in the next few days and to answer any questions you may have concerning your award.

Thank you again for your continued commitment to make significant changes to your long-term support system. The immense opportunities inherent in the Money Follows the Person Rebalancing Demonstration can truly create dynamic systems that are responsive to the needs and choices of individuals who are disabled and elderly.

Sincerely,


Cindy Mann
Director

Enclosures

Documents regarding your Money Follows the Person Rebalancing Demonstration Grant Program Award:

1. **Terms and Conditions** - This legal document cites the regulations governing the grant and sets forth the general requirements, assurances, reporting requirements, and other terms and conditions that apply specifically to the grant.
 - General Terms & Conditions
 - Programmatic Terms & Conditions
 - Grant Specific Terms & Conditions
2. **Notification of Award (NOA)** – This document is the “official” notification of your award from the CMS Office of Acquisition and Grants Management.

cc:

Adele Edelman, Director of Adult Services Unit
Julie McCarthy, Regional Office Analyst
Grants Management Specialist
Jeffrey Clopein, CMS Project Officer



CMS STANDARD TERMS AND CONDITIONS

Terms of Award

With the acceptance of a grant or cooperative agreement from CMS, the grantee has the responsibility to be aware of and comply with the terms and conditions of award.

Individual awards are based on the application submitted to, and as approved by, CMS and are subject to the terms and conditions incorporated either directly or by reference in the following:

- The grant program legislation and program regulation cited in the Notice of Grant Award.
- The restrictions on the expenditure of Federal funds in the appropriation acts, to the extent those restrictions are pertinent to the award.
- 45 CFR Part 74 and 45 CFR Part 92 as applicable.
- The Notice of Award including all terms and conditions (standard and special) cited on the document or attachments.
- DHHS Grants Policy Statement (at <http://www.hhs.gov/grantsnet>)

45 CFR Part 74 and 45 CFR Part 92 (Regulations Governing CMS Grants)

Regulations found at Title 45, Code of Federal Regulations (CFR), Part 74 and Part 92, are the rules and requirements that govern the administration of Department of Health and Human Services (DHHS) grants.

Part 74 is applicable to all grantees except those covered by Part 92, which governs awards to state and local governments.

These regulations are a term and condition of award. Grantees must be aware of and comply with the regulations. (May be accessed by internet from DHHS at <http://www.hhs.gov/grantsnet>.)

Cost Principles

Cost Principles of allowable and unallowable expenditures for CMS grantees are provided in the following documents:

- **Institutions of Higher Education:** OMB Circular A-21 ("Cost Principles for Educational Institutions")
- **State and Local Governments:** OMB Circular A-87 ("Cost Principles for State, Local, and Indian Tribal Governments")
- **Nonprofit Organizations:** OMB Circular A-122 ("Cost Principles for Non-Profit Organizations")
- **Appendix E Hospitals:** 45 CFR Part 74
- **For-profit Organizations:** 48 CFR (Federal Acquisition Regulations System), Subpart 31.2 (Contract Cost Principles and Procedures)

Administrative Standards

In addition to the cost principles, OMB has established administrative standards and audit requirements for organizations receiving Federal assistance. These administrative standards are contained in the following documents:

- **State and Local Governments:** OMB Circular A-102 ("Grants and Cooperative Agreements with State and Local Governments")
- **Higher Education, Hospitals, and Other Nonprofit Organizations:** OMB Circular A-110 ("Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations")
- **Audits of States, Local Governments, and Nonprofit Organizations:** OMB Circular A-133
- **Copies of the Office of Management and Budget (OMB) Circulars are available on the Internet at:** <http://www.whitehouse.gov/OMB/circulars/>
- **Federal Acquisition Regulations (FAR) (48 CFR Part 31) are also available from the Internet at:** <http://www.arnet.gov/far/>

Grant Payment

Payments under these awards are made available through the Payment Management System (PMS). PMS is administered by the Division of Payment Management

<http://www.dpm.psc.gov>. Grantees should contact PMS directly for instructions on how to obtain payments. Inquiries should be directed to:

Director, Division of Payment Management, OS/ASAM/PSC/FMS/DPM
P.O. Box 6021
Rockville, MD 20852
Telephone: 1-877-614-5533

Reporting Requirements

Financial Reports - The grantee agrees to submit federal financial reports (SF-425 to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the special terms and conditions. Unless specified as quarterly or semi-annual in the Special Terms and Conditions, financial reports are due annually and at the end of the project. This federal financial report will account for all uses of grant monies during the previous period and project uses of grant money for the ensuing period. Quarterly and semi-annual reports are due 30 days after the end of the reporting period. Annual reports are due 90 days after the budget period ending date. Final SF-425 reports are due for all grants 90 days after the end of the project and encompass costs throughout the project as required in 45 CFR Part 74 and 92 and the HHS Grants Policy Statements.

Grantees shall liquidate all obligations incurred under the award not later than 90 days after the end of the project period. IMPORTANT- The SF-425 (Federal Financial Report submitted to PMS) and (Federal Financial Report submitted to CMS) must equal before submitting final reports to CMS.

Progress Reports – The grantee agrees to submit progress reports to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the special terms and conditions. Unless specified as quarterly or semi-annual in the Special Terms and Conditions, progress reports are due annually. These reports are to be consistent with a format and content specified by CMS. CMS reserves the right to require the grantee to provide additional details and clarification on the content of the report. Quarterly and semi-annual reports are due 30 days after the end of the reporting period. Annual reports are due 90 days after the budget period ending date.

Final Progress Report - The final report is due within 90 days after the project period date of the last year of the grant. A draft final report should be submitted to the CMS Project Officer for comments. CMS's comments should be taken into consideration by the grantee for incorporation into the final report.

The final progress report may not be released or published without permission from the CMS Project Officer within the first four (4) months following the receipt of the report by the CMS Project Officer.

The final report will contain a disclaimer that the opinions expressed are those of the grantee and do not necessarily reflect the opinion of CMS.

Failure to submit reports (i.e., financial, progress, or other required reports) on time may be basis for withholding financial assistance payments, suspension, termination or denial of refunding. A history of such unsatisfactory performance may result in designation of "high risk" status for the grantee organization and may jeopardize potential future funding from DHHS.

Use of Federal Funding

When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments and recipients of Federal research grants shall clearly state (1) the percentage of total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the program or project, and (3) the percentage and dollar amount of the total costs of the program or project that will be financed by nongovernment sources.

Project and Data Integrity

The grantee shall protect the confidentiality of all project-related information that identifies individuals.

The grantee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS Project Officer shall not direct the interpretation of the data used in preparing these documents or reports.

At any phase in the project, including the project's conclusion, the grantee, if so requested by the Project Officer, must deliver to CMS materials, systems, or other items used, developed, refined or enhanced in the course of or under the award. The grantee agrees that CMS shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes.

Use of Data and Work Products

At any phase of the project, including the project's conclusion, the grantee, if so requested by the CMS Project Officer, shall submit copies of analytic data file(s) with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the Principal Investigator and the CMS Project Officer. The negotiated format(s) could include both file(s) that would be limited to CMS's internal use and file(s) that CMS could make available to the general public.

All data provided by CMS will be used for the research described in this grant only. The grantee will return any data provided by CMS or copies of data at the conclusion of the project.

For six (6) months after completion of the project, the grantee shall notify the CMS Project Officer prior to formal presentation of any report or statistical or analytical material based on information obtained through this award. Formal presentation includes papers, articles, professional publication, speeches, and testimony. In the course of this research, whenever the Principal Investigator determines that a significant new finding has been developed, he/she will communicate it to the CMS Project Officer before formal dissemination to the general public.

Major Alteration and Renovation Costs

Approved alteration/repair/renovation projects with a net project cost (excluding equipment) greater than \$500,000 require the grantee to:

- File a Notice of Federal Interest (NFI) with the appropriate jurisdictional records, and
- Submit a notarized and recorded copy of the NFI to the Grants Management Specialist

Audit Requirements

Audit requirements for Federal award recipients are defined in OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations.

An organization is required to have a non-Federal audit if, during its fiscal year, it expended a total of \$500,000 (\$300,000 for fiscal years ending before December 31, 2003) or more in Federal awards. Federal awards are defined in OMB Circular A-133 to include Federal financial assistance and Federal cost reimbursement contracts received both directly from a Federal awarding agency as well as indirectly from a pass-through entity.

45 CFR 74.26(d) discusses the requirements and available non-Federal audit options for Department of Health and Human Service awards. Two audit options are available to commercial organizations. One option is a financial related audit as defined in the Government Auditing Standards, GPO stock #020-000-00-265-4 (commonly known as the Yellow Book) of all DHHS awards; the second option is an audit that meets the requirements of OMB Circular A-133.

Commercial organizations that receive annual DHHS awards totaling less than the OMB Circular A-133's audit requirement threshold are exempt from a non-Federal audit for that year, but must make records available for audit or review as requested by CMS or other designated officials.

OMB Circular A-133 now requires that all auditees submit a completed data collection form (SF-SAC) in addition to the audit report. For questions and information concerning the submission process, please visit <http://harvester.census.gov/sac/> or you may call the Federal Audit Clearinghouse (888-222-9907).

Audit reports for both CMS and other HHS awards with fiscal periods ending on or after January 1, 2008 shall be submitted online via <http://harvester.census.gov/sac/>. Audit reports with fiscal periods ending in 2002 – 2007 must be mailed to the address shown below:

Federal Audit Clearinghouse
Bureau of the Census
1201 E. 10th Street
Jeffersonville , IN 47132

Fraud and Abuse

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Certification of Filing and Payment of Federal Taxes

As required by the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Act, 2008 (Public Law 110-161, Division G, Title V, section 523), as a financial assistance recipient entering into a grant or cooperative agreement, the grantee certifies that:

(1) All Federal tax returns have been filed during the three years preceding this certification;

AND

(2) There has been no conviction of a criminal offense pursuant to the Internal Revenue Code of 1986 (U.S. Code – Title 26, Internal Revenue Code);

AND

(3) Not more than 90 days prior to this certification, been notified of any unpaid Federal tax assessment for which the liability remains unsatisfied, unless the assessment is the subject of an installment agreement or offer in compromise that has been approved by the Internal Revenue Service and is not in default, or the assessment is the subject of a non-frivolous administrative or judicial proceeding.

Trafficking In Persons

a. Provisions applicable to a recipient that is a private entity.

1. You as the recipient, your employees, sub-recipients under this award, and sub-recipients' employees may not—

- i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
- ii. Procure a commercial sex act during the period of time that the award is in effect; or
- iii. Use forced labor in the performance of the award or sub-awards under the award.

2. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a sub-recipient that is a private entity –

- i. Is determined to have violated a prohibition in paragraph a.1 of this award term; or
- ii. Has an employee who is determined by the agency official authorized to terminate the award to have violated a prohibition in paragraph a.1 of this award term through conduct that is either—

A. Associated with performance under this award; or

B. Imputed to you or the sub-recipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, “OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Non-procurement),” as implemented by our agency at 2 CFR part 376.

b. **Provision applicable to a recipient other than a private entity.** We as the Federal awarding agency may unilaterally terminate this award, without penalty, if a sub-recipient that is a private entity—

1. Is determined to have violated an applicable prohibition in paragraph a.1 of this award term; or

2. Has an employee who is determined by the agency official authorized to terminate the award to have violated an applicable prohibition in paragraph a.1 of this award term through conduct that is either—
 - i. Associated with performance under this award; or
 - ii. Imputed to the sub-recipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, “OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Non-procurement),” as implemented by our agency at 2 CFR part 376

c. Provisions applicable to any recipient.

1. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph a.1 of this award term
2. Our right to terminate unilaterally that is described in paragraph a.2 or b of this section:
 - i. Implements section 106(g) of the Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. 7104(g)), and
 - ii. Is in addition to all other remedies for noncompliance that are available to us under this award.
3. You must include the requirements of paragraph a.1 of this award term in any sub-award you make to a private entity.

d. Definitions. For purposes of this award term:

1. “Employee” means either:
 - i. An individual employed by you or a sub-recipient who is engaged in the performance of the project or program under this award; or
 - ii. Another person engaged in the performance of the project or program under this award and not compensated by you including, but not limited to, a volunteer or individual whose services are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.

2. "Forced labor" means labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.
3. "Private entity":
 - i. Means any entity other than a State, local government, Indian tribe, or foreign public entity, as those terms are defined in 2 CFR 175.25.
 - ii. Includes:
 - A. A nonprofit organization, including any nonprofit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR 175.25(b).
 - B. A for-profit organization.
4. "Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C. 7102)

Federal Financial Accountability and Transparency Act (FFATA) Subaward and Executive Compensation Reporting Requirement

This award may be subject to the Federal Financial Accountability and Transparency Act (FFATA) subaward and executive compensation reporting requirements of 2 CFR Part 170.

Requirements for CCR and DUNS

- a. Requirements for CCR
Unless your entity is exempt from this requirement under 2 CFR 25.110, it is incumbent upon you, as the recipient, to maintain the accuracy/currency of your information in the CCR until the end of the project. Additionally, this term requires your entity to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term.
- b. Requirements for DUNS numbers:
If you are authorized to make subawards under this award, you:

- Must notify potential subrecipients that no entity may receive a subaward from you unless the entity has provided its DUNS number to you.
- May not make a subaward to an entity unless the entity has provided its DUNS number to you.



Money Follows the Person (MFP) Rebalancing Demonstration Programmatic Special Terms and Conditions 2011

Operational Protocol (OP)

1. **Initial Approval**– Grantees will have up to thirty days to revise and resubmit the OP based on the Grant Specific Terms and Conditions which are included in this grant award notification for review by your assigned Project Officer. All revisions required in the terms and conditions that affect the Worksheet for Proposed Budget should be reflected in the revised worksheet. A revised SF424A Form (section B) reflecting the changes in the line items (i.e., Personnel, Fringe, Travel, Other- *service costs*, ect.) must also be submitted. The CMS Project Officer will review and either approve, or request further revisions to the OP within 10 days of receipt from the grantee. This process will continue until the grantee receives approval of the OP.
2. **Prior to OP Approval-Restrictions on the use of grant award funding**- Grantees may begin to expend budgeted administrative award funding up to the allowable cap indicated in your Grant Specific Terms and Conditions. States who received planning grant funding must expend those grant award funds prior to expending MFP demonstration grant funding. Award funds for service expenditures are restricted until the grantee receives an OP approval letter from CMS.
3. **Future Revisions of an approved OP:** All proposed revisions to the State's approved MFP demonstration program and to the State's Operational Protocol that are the result of changes in policy or operating procedures and budget revisions must be submitted for review and approval by CMS as per the OP Amendment Protocol. The State must submit a request to CMS, through their CMS Project Officer, for these changes no later than 30 days prior to the date of implementation of the change(s). Revisions must include an implementation date for the proposed changes and a revised budget as appropriate.

Financial and Programmatic Reporting: The grantee agrees to the following reporting requirements:

Programmatic Reporting Requirements

All grantees will be required to submit semi-annual web-based reports that address various aspects of program implementation. The data collected in the reports will provide the national evaluation contractor with information on:

- **Structure** – implemented programmatic changes to rebalance resources and transition and maintain individuals in the community, i.e., systems changes, agency changes;
- **Process** – implemented strategies and procedures of the MFP program including Quality Management Strategy ;
- **Output** – products of the MFP program, i.e., waiver and State plan amendments, State legislation, agency changes; new policies, new procedures;
- **Outcomes**—results of the MFP program, i.e., what changed, who was transitioned, what

populations, community settings where transitioned individuals moved; and

- **Impact** – Consumer outcomes, i.e., continuity of services, appropriateness of services delivered based on assessment, utilization of services after transition, length of stay in the community, consumer satisfaction.

Financial Reporting Requirements

All grantees will be required to submit financial reporting forms on a quarterly, semi-annual, or annual basis. Below are brief descriptions of the required forms:

1. *CMS 64.9i, 9Pi and 64.10i, 10Pi* - These forms, submitted on a quarterly basis, allow the State and CMS to track expenditures associated with the demonstration participants. The various forms feed into the Medicaid Budget and Expenditure System (MBES), but are not used to draw down funding. They are informational forms that will provide a mechanism for adequately projecting estimates on expenditures once the participant leaves the demonstration.
2. *MFP Program Files* – This files will be submitted quarterly to the national evaluation contractor. The files will be used to track program enrollment patterns, participant quality of life, and Medicaid claims records extracted from the Medicaid Statistical Information System (MSIS) for each demonstration participant. The quarterly files will be sent to the national Evaluation contractor via the Gentran system.
3. *MFP Financial Reporting Forms (A, B, C, and D)* - The MFP Financial Reporting Forms, submitted on a quarterly basis, are modified from the CMS 64. The forms provide a mechanism for tracking expenditures for Qualified HCBS, Demonstration and Supplemental, Services offered under the demonstration, as well as administrative claims that will require reimbursement from demonstration funds. The MFP Financial Reporting Forms should be submitted to the MFP Financial mailbox at MFP@cms.hhs.gov.
4. *Federal Financial Report, form (SF-425)* - This mandated financial status report will account for all uses of grant monies during each reporting period. For purposes of this demonstration, the SF-425 must be submitted semi-annually (a mid-year and end-of-year report). The SF-425 should be submitted to the CMS Grants Office and the MFP Financial mailbox at MFP@cms.hhs.gov.
5. *Payment Management System (PMS) Smartlink SF-425*- This form, submitted on a quarterly basis to the Payment Management System (www.dpm.gov) for grant award funds, is an aggregate accounting of grantees' draws from the CMS PMS to pay for demonstration expenditures and then reporting those aggregate expenditures.
6. *Maintenance of Effort (MOE) form* – This form will capture all LTC expenditures (both community and institutional) annually to ensure that the State has maintained its financial effort taking into account all service costs, administrative costs, and rebalancing investments. The MOE Form should be submitted to the CMS Grants Office and the MFP Financial mailbox at MFP@cms.hhs.gov.
7. *MFP Worksheet for Proposed Budget* – This form, submitted on an annual basis by January 31 of each year and will provide CMS with a standardized report of each State's high level budget information, as well as projected transition benchmark information.

Initial & Supplemental Awards

Initial Awards

Grantee's first year award (for calendar year 2011) is included in this award notification as well as the CMS commitment for a six year period 2011-2016. In 2015 CMS will request grantees to submit a Worksheet for Proposed Budget for the calendar year 2015- Federal Fiscal Year 2020.

Supplemental Award Process:

CMS will award supplemental funding for all subsequent years of the demonstration with the following conditions:

- The grantee must submit a request for a supplemental award, to the CMS as per instructions (by electronic mail to the MFP Financial mailbox at MFP@cms.hhs.gov and your CMS Project Officer and one hard copy to the CMS Grants Officer by January 31st, of each year. The supplemental award request must include a letter of request, and the following forms:
 - MFP Maintenance of Effort Form for the new calendar year.
 - MFP Worksheet for Proposed Budget –will provide CMS with a standardized report of high level budget information for the budget year and out years, as well as projected transition benchmark information.
- The grantee must be in full compliance with all CMS specified MFP financial and programmatic reporting requirements.
- **Grantees may request additional supplemental funding at any time.** If a grantee is exceeding their benchmark in the number of transitions and requires additional funds in the grant account, CMS will process a supplemental request outside of the yearly request schedule. A request made other than January 31 of each year must include a signed Request letter with justification, a 424 Supplement Request Form sent to your Project Officer and to the CMS Grants Officer.
- After the first year of implementation, the process for issuing MFP supplemental awards will also incorporate a review of the grantee's progress in the achievement of the two required annual benchmarks. These benchmarks, and any revisions to the benchmarks, must have been proposed by the State, and approved by CMS. MFP supplemental funding is contingent upon the attainment of the required benchmarks.

Governing Requirements:

All the requirements in the statutes (Section 6071 of the Deficit Reduction Act of 2005 and Section 2403 of the Affordable Care Act) and the solicitation, Money Follows the Person Rebalancing Demonstration CFDA 93.791, as well as all additional Policy Guidance posted on the CMS Technical Assistance website (www.mfp-ta.com) are governing components of this award. Further, the State agrees to abide by future Policy Guidance that further refines the MFP requirements.

Cooperation with the MFP National Evaluation Contractor All awardees must continue to cooperate with the CMS contractors working in support of the MFP Demonstration. The

grantee agrees to participate in all efforts, by CMS and its contractors, to evaluate the programmatic elements and operational components of the State's demonstration program. As required by The Congress in the Deficit Reduction Act of 2005, The Secretary must make a final report to the President and Congress, not later than September 11, 2016 providing the findings and conclusions on the conduct and effectiveness of the MFP demonstration projects. To that end, the MFP demonstration grantee agrees to work in partnership with CMS and its contractor, to help ensure the validity and completeness of the State's information used for the National evaluation.

The following are required:

- Minimum Data Set: The State will submit the finder files, services file and quality of life file required by this demonstration, timely, in accordance with the schedule that has been provided.
- Submission of data to CMS: CMS has provided a file transfer protocol delineating the process for forwarding its research data to CMS in a timely manner. The State agrees to employ this protocol.
- The grantee must administer, to CMS' full specifications, the Quality of Life Survey. This survey must be administered within the timeframes and methodology specified by CMS and must include, in its efforts, a number of MFP participants as determined by CMS. The revised budget submitted by the grantee will include the request for 100% federal funding for the second and third fielding of this survey for each participant.
- Use and access to all evaluative data will be limited to the specific research purposes of these projects and shall adhere to all CMS provisions concerning data release policies, the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act of 1996.

Cooperation with the Contractor for Quality Assurance and Improvement, Technical Assistance and Oversight

- Technical Assistance (TA): The Grantee must fully cooperate with the contractor(s) engaged in the Technical Assistance Assessment and the provision of Technical Assistance requested by CMS for the grantee. The grantee further agrees to comply with the technical assistance plan that has been or will be developed by the contractor, and approved by CMS in cooperation with the grantee. The grantee may request technical assistance directly from the TA contractor at any time.

Separating Medicaid Service Claims from MFP claims against grant funds:

- The MFP Grantees must use existing Medicaid reporting systems including MSIS clearly separating the reimbursements for approved services that are billable under the MFP grant from those services to be billed through regular Medicaid reimbursement procedures.

MFP Conferences:

- For the duration of this grant award, the grantee agrees to attend CMS sponsored National meetings dedicated to the interests of the CMS MFP Demonstration Program. The location, date, and time of these meetings will be determined by CMS. The grantee is expected to have, at a minimum, the MFP Project Director, in attendance at scheduled meetings. CMS will reimburse the grant for travel expenses including transportation, lodging, meals or per diem payments for meals, as per each States travel procedures, for up to three attendees.

Site Visits by CMS

- CMS will conduct grant monitoring site visits with the first site visit within twelve months from the date of award. Site visits will require an entry and exit conference with all participating department and agency leaders including the Medicaid Director. Programmatic discussions with grant staff and home visits to demonstration participants from each population served will be scheduled. CMS may recommend MFP program changes or revisions to the state's Operational Protocol based on the site visit findings.

Product Development:

- At any phase in the project, including the project's conclusion, the grantee if requested by the CMS Project Officer, must deliver to CMS materials, systems, or other products applied, developed, refined or enhanced in the course of or under the award. The grantee agrees that CMS shall have royalty-free, nonexclusive or irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes.

Use of HCBS.org:

- The grantee is required to post CMS-grant funded work products on HCBS/Clearinghouse for Community Living Exchange Collaboration. This website, located at www.hcbs.org, serves as a CMS repository of resources related to community based services and supports.

Selling products:

If the grantee intends to sell grant products, the following criteria must be applied:

- The information must be made available to other Federal grantees at no cost.
- The hcbs.org website must include a description of the product with a statement that it may be purchased, and a clarification that it is available to other grantees without charge. A contact person must be identified.
- Any funds obtained from the sale of the product must be reinvested in grant activities.

Work Products Resulting from Grant Funds:

The grantee agrees to include the following attribution and disclaimer on all materials developed for public distribution, which are funded under the grant:

“This document was developed under grant CFDA 93.791 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the

U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.”

In addition, the grantee agrees that all materials developed through Federal grant funding will be made accessible to people with special needs meeting requirements to be 508 compliant.

Project Director:

- Grantees must continue to employ a Project Director with sufficient authority to manage the rebalancing demonstration program, dedicated full-time to the MFP project without financial conflicts of interest in the project. Should a Project Director cease to fulfill the role as full-time MFP Project Director, the grantee shall immediately notify and submit a plan to CMS for continued management of demonstration operations until a new Project Director is hired and engaged in the administration and operation of the Demonstration. The grantee shall submit the resume of the new Project Director to CMS project officer for advice and consent.
- CMS may request that a Project Director that fails to meet the requirements of the demonstration including timely submission of reports, responsive communications, adherence to the budget and operational protocol, participation in national calls and conferences or, in any way proves unable to carry out the duties and responsibilities of the position be removed from the demonstration and replaced by a Project Director acceptable to CMS through review and consultation with the State.

Maintenance of Effort (MOE) Form
Money Follows the Person Demonstration Grant Program (Nov 2010)

STATE:	VT	Grant #:	CMS-1LI-11-001
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Reporting Year Format: State Fiscal Year X (Fiscal YEAR RUNS: July 1-June 30)
 FEDERAL FISCAL YEAR _____ Calendar Year _____

Total State Expenditures for Home & Community-based Services

Base Year					
	2007	2008	2009	2010	2011
				\$16,669,774	

State Share

	2012	2013	2014	2015	2016	2017

2018	2019

Attestation (required by Section 6071 of the Deficit Reduction Act of 2005)

I assert by my signature that the expenditure report above is accurate and follows the MFP MOE Form instructions. I also assert that all qualified HCBS programs operating under a waiver under section (d) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

Signature :	<i>William R. Kelly</i>	Date:	<i>3/24/11</i>
Title/Position:	<i>Financial Services Director</i>		

Instructions

1. Fill out your State and Official Grant Number.
2. Check off the Report year you will be using. If it is the State Fiscal Year, indicate the dates of the year the report covers. You must report by either State FY, Federal FY or Calendar year.
3. Fill in each year's expenditures for HCBS starting with the base year which you will fill in. The base year is the immediate previous full year of expenditures based on the reporting year format you have chosen. For new applicants for 2011 provide only your base year. For existing grantees only provide the base year and the first full year you began your grant through the latest reporting period.
4. Medicaid HCBS Expenditures include all non-institutional services and include waiver and HCBS State plan services such as personal care services, rehab services and other State plan services you cover that are non-institutional.
5. The State authorized signatory must sign and date as well as identify their Title or position as indicated. The second element to attest to is the continuation of meeting cost neutrality in the waivers your State provides.



FOR IMMEDIATE RELEASE
February 22, 2011

Contact: HHS Public Affairs
(202) 690-6343

***Affordable Care Act Supports Vermont in Strengthening Community Living
Nationally, \$4.3 Billion in New Funds Announced to Help Establish and Expand
Community-based Alternatives to Institutional Long Term Care***

States will see significant new federal support in their efforts to help move Medicaid beneficiaries out of institutions and into their own homes or other community settings now and in the near future, Health and Human Services (HHS) Secretary Kathleen Sebelius announced today.

The Affordable Care Act provides additional funding for two programs supporting that goal, the Money Follows the Person (MFP) demonstration program and the Community First Choice Option program. Today, Secretary Sebelius announced thirteen States would together receive more than \$45 million in MFP grants to start that program in their States, with a total of \$621 million committed through 2016. Vermont will receive funds totaling 17,963,059 through 2016 for this program.

In addition, HHS has proposed rules to allow all States to access a potential of \$3.7 billion in increased federal funding to provide long-term services and supports through the Community First Choice Option program.

“Our country recognized in the Americans with Disabilities Act that everyone who can live at home or community-based setting should be allowed to do so,” Secretary Sebelius said. “The Affordable Care Act provides States critical new dollars toward achieving that goal.”

Thirteen States Receive Money Follows the Person Program Grants

The Money Follows the Person (MFP) demonstration program, which was set to expire in fiscal year 2011, is extended through the Affordable Care Act for an additional five years. Vermont is one of 13 States receiving awards today (see list and award amounts below), joining the 29 States and the District of Columbia already operating MFP programs. Together, these States will receive more than \$45 million in the first year of the program, and more than \$621 million through 2016.

The MFP program provides individuals living in a nursing home or other institution new opportunities to live in the community with the services and supports they need. Groups benefiting from these home-and-community based programs include the elderly, persons with intellectual, developmental and/or physical disabilities, mental illness or those diagnosed with several conditions. To date, these programs have helped



12,000 individuals move out of institutions and back into their communities. Today's grants are expected to help an additional 13,000 people.

"The Money Follows the Person program is hugely important to improving the lives of Medicaid beneficiaries," said Donald Berwick, M.D., administrator of the Centers for Medicare & Medicaid Services (CMS), which will implement the demonstration program. "This helps bring everyone, even those who in the past may have had no choice but to live in an institution, into the community where they can become full participants in the activities most of us take for granted."

New Community First Choice Option Available to States

Many of the same goals under the MFP demonstration are shared and supported by the Community First Choice (CFC) Option, created by the Affordable Care Act. Today, nursing homes and institutions are too often the first or only choice for people with Medicaid who need long term care. The goal of this new option is to give States additional resources to make community living a first choice, and leave nursing homes and institutions as a fall back option.

Starting in October, this option will allow States to receive a six percent increase in federal matching funds for providing community-based attendant services and supports to people with Medicaid. Over the next three years—through 2014—States could see a total of \$3.7 billion in new funds to provide these services. States currently receive Federal Medicaid matching funds for these activities at the State's normal matching rate.

Services and supports that can be provided under CFC include, but are not limited to, attendant services and supports that help individuals with activities of daily living such as bathing and eating, and health-related tasks through hands-on assistance or supervision. States may also cover costs related to moving individuals from an institution to the community, such as security and utility deposits, first month's rent, and purchasing basic household supplies.

To qualify for the increased Federal funds, States must develop "person-centered plans" that allow the individual to determine how services are provided to achieve or maintain independence. States must also establish implementation councils with a majority membership consisting of persons with disabilities, elderly individuals and their representatives to advise in the design and implementation of Community First Choice option. The proposed rule, posted today, describes the details of this program and solicits public comment. The rule can be found at: http://www.ofr.gov/OFRUpload/OFRData/2011-03946_PI.pdf.

"There is more evidence than ever that people who need long-term care prefer to live in their own homes and communities whenever possible," said Dr. Berwick. "To restrict these individuals to institutions where even the simplest decisions of the day such as when to get up, what to eat and when to sleep are made by someone else must

no longer be the norm. This new Federal funding will make a difference in people's lives."

MONEY FOLLOWS THE PERSON DEMONSTRATION GRANTS

See below for the list of States receiving MFP grants today.

Money Follows the Person Grant Awardees			
State	Grantee	1st YR. Award	Funds committed through 2016
Colorado	Colorado Department of Health Care Policy & Financing	\$2,000,000	\$22,189,486
Florida	Florida Agency for Health Care Administration, Medicaid	\$4,203,999	\$35,748,853
Idaho	Idaho Department of Health and Welfare, Division of Medicaid	\$695,206	\$6,456,560
Maine	Maine Department of Health and Human Services	\$699,970	\$7,151,735
Massachusetts	Massachusetts Executive Office of Health & Human Services, Office of Medicaid	\$13,486,888	\$110,000,000
Minnesota	Department of Human Services	\$13,421,736	\$187,412,620
Mississippi	Mississippi Division of Medicaid, Office of Health Services	\$1,341,394	\$37,076,814
Nevada	Nevada Department of Health & Human Services, Division of Health Care Financing & Policy	\$800,000	\$7,276,402
New Mexico	New Mexico Human Services Department, Medical Assistance Division, Long Term Services & Supports Bureau	\$595,839	\$23,724,360
Rhode Island	Rhode Island Department of Human Services, Division of Health Care Quality, Financing & Purchasing / Medicaid Division	\$2,503,021	\$24,570,450
Tennessee	Tennessee Bureau of TennCare	\$2,357,733	\$119,624,597
Vermont	Department of Disabilities, Aging and Independent Living	\$2,123,975	\$17,963,059
West Virginia	West Virginia Department of Health & Human Resources, Bureau for Medical Services	\$1,267,373	\$22,220,423
TOTAL		\$45,497,134	\$621,415,359

MONEY FOLLOWS THE PERSON FEASIBILITY ANALYSIS

INTRODUCTION

The Department of Aging and Independent Living (DAIL) is evaluating whether to submit an application for federal funding under the Money Follows the Person (MFP) rebalancing grant demonstration. MFP grant funds would be used to develop a program to facilitate the discharge of qualifying nursing facility residents back into the community. The program would operate under the aegis of Choices for Care.

A decision as to whether to submit a grant application must be made by late November, to allow sufficient time for stakeholder outreach and drafting of the application, due to CMS on January 7, 2011. DAIL retained the Pacific Health Policy Group (PHPG) to conduct a feasibility analysis for the MFP grant as part of the decision making process.

PHPG's analysis examined three program aspects:

- The estimated number of Vermont nursing facility residents who meet MFP eligibility criteria, as described below;
- Barriers to the return of these residents to the community (i.e., service gaps) that would have to be addressed as part of the MFP demonstration;
- The potential financial impact of the MFP program resulting from the transition of nursing facility residents back to the community and reimbursement of some services by the federal government at an enhanced matching rate

PHPG addressed the first two portions of the feasibility analysis by conducting onsite interviews with nursing facility staff at eleven facilities located throughout the state. The facilities were selected to be representative of the industry at large and accounted for nearly 40 percent of all Medicaid days in July 2010. They also accounted for 54 percent of all Medicaid-eligible residents classified as "low case mix" in SFY 2010.

Findings from the onsite interviews are presented below. The estimated number of MFP-eligible residents at the facilities was incorporated into the financial analysis presented in the final section of the report.

ONSITE INTERVIEWS

The onsite interview sample consisted of eleven nursing facilities selected to be representative of the state in terms of Medicaid census, bed size, location, and resident characteristics. Each nursing facility was visited by a Registered Nurse who interviewed the Administrator and/or Social Workers to determine:

- Number of residents who meet MFP eligibility criteria, specifically:
 - Have Medicaid as his/her payor for nursing facility services;
 - Have been a resident of a nursing facility for more than 90 consecutive days with Medicaid as the primary payer. This excludes any days the individual's primary payer was Medicare or the individual was residing in the institution for the sole purpose of receiving short-term rehabilitation services that are reimbursed under Medicaid; and
 - Have expressed a desire to return to a community setting (home or residential care).

- Breakdown of MFP-eligible residents by characteristics, including but not limited to:
 - Low case mix;
 - Physically disabled;
 - Geriatric with behavioral health issues;
 - Cognitive Impairment; and
 - Cognitive Impairment with Traumatic Brain Injury (TBI)

- Barriers preventing these residents from leaving the nursing facility and returning to the community; and

- Additional or enhanced benefits that would facilitate a return to the community either in a home or residential setting).

Residents Meeting MFP Criteria

The PHPG Registered Nurse began by reviewing MFP criteria with nursing facility representatives to identify residents who would be candidates for discharge under the demonstration. In an effort to be conservative in estimating the demonstration's potential impact, PHPG accepted nursing facility estimates without modification¹.

¹PHPG did perform one validation exercise. The information collected through onsite interviews was compared, where available, to resident-specific data compiled by DAIL Long Term Care Clinical Coordinators (LTCCCs) as part of their routine utilization review activities. The interview findings were found to be very similar to the LTCCC reports, supporting the notion that interview results could reasonably be extrapolated to all nursing facilities in the state in order to estimate the total Vermont MFP-eligible population.

Exhibit 1 below identifies the number of MFP-eligible residents in each nursing facility, in total and by resident characteristic. Residents were included in only one category apiece, to arrive at an unduplicated count. However, many residents had characteristics that crossed two or more categories. In such cases, the resident was categorized by on his/her dominant characteristic.

Exhibit 1 - Residents Meeting MFP Criteria

Nursing Facility	Low Case Mix	Physically Disabled	Mild to Moderate Geriatric/ Behavioral	Cognitive Impairment	Cognitive Impairment with TBI	Total
1. Birchwood Terrace	3	--	--	2	--	5
2. Centers for Living & Rehab	2	--	--	--	--	2
3. Crescent Manor	1	1	--	1	--	3
4. Mountain View Center	2	--	--	1	--	3
5. Newport Health Center	4	--	--	1	--	5
6. Pines at Rutland	--	--	--	--	--	--
7. Rutland Health Care	--	--	--	--	--	--
8. Starr Farm	3	1	--	--	1	5
9. Thompson House	3	--	--	--	--	3
10. Vermont Veterans	8	2	2	--	--	12
11. Woodridge	1	--	--	--	--	1
TOTAL	27	4	2	5	1	39

Barriers to Transition

PHPG explored barriers to transition, by resident type, with nursing facility representatives. While barriers particular to a few groups were identified (see below), a number of the most significant barriers applied to all resident types. These include: lack of family support and corresponding affordable and accessible housing alternatives; safety concerns, particularly in the absence of home modifications; limited adult day and respite care; and need for assistance with medication management.

The lack of housing alternatives and adult day/respite care were more significant issues in rural areas of the state than in Burlington and other larger communities. Nursing

facilities in rural areas also identified the need for additional transportation services and assistance with snow removal in the winter as significant concerns.

Residents with physical disabilities continue to require physical assistance to transfer and/or the use of a Hoyer lift in a home or community setting. These residents are appropriate candidates for Enhanced Residential Care (ERC) or Adult Family Care placements, but confront waiting lists of up to two years (as reported to PHPG by the nursing facilities).

Residents with traumatic brain injury have the desire to return to their own homes. However, the home (and their family) may not be equipped to handle their needs without 24-hour assistance. If a resident wants to go home and can, the nursing facilities report they make every effort to facilitate the discharge.

Residents with cognitive impairment are at heightened risk for falls and elopement. Many community-based settings lack secure units and 24 hour monitoring, making them ill suited for persons with cognitive impairment. Nursing facilities reported to PHPG that families often are overwhelmed by caring for relatives with cognitive impairments and do not believe they can provide a safe in-home environment.

Finally, residents with significant behavioral health needs face barriers that go beyond transitioning into the community. These include (as reported by nursing facilities) limited group home capacity; lack of community psychiatric and other behavioral health services for the geriatric population; and limited experience with behavioral health residents within assisted living facilities.

Exhibit 2 below summarizes the significant barriers to transition by resident type.

Exhibit 2 – Barriers to Transition

Barriers to Transition	Low Case Mix	Physically Disabled	Mild to Moderate Geriatric/ Behavioral	Cognitive Impairment	Cognitive Impairment with TBI
1. Lack of family support to return home	X	X	X	X	X
2. Limited affordable/ accessible housing	X	X	X	X	X
3. Limited adult day care capacity ²	X	X	X	X	X
Barriers to Transition	Low Case Mix	Physically Disabled	Mild to Moderate	Cognitive Impairment	Cognitive Impairment

² Applies to rural areas of the state.

	Geriatric/ Behavioral				with TBI
4. Safety concerns; risk for falls	X	X	X	X	X
5. Risk for elopement; need for secure sites/alarms			X	X	X
6. Home modification requirements	X	X	X	X	X
7. 24-hour monitoring requirements		X	X	X	X
8. Physical assist requirements (e.g., Hoyer lift; transfer aid)		X			X
9. Limited alternative residential (ERC, AFC etc.)		X	X	X	X
10. Limited community psych/other BH services			X		
11. Limited experience with BH residents in assisted living			X		
12. Limited night and weekend respite care	X	X	X	X	X
13. Limited access to transportation ³	X	X	X	X	X
14. Medication management assistance requirement	X	X	X	X	X

MFP and Development of Additional Services

The facilities interviewed agreed that the MFP demonstration would be helpful to those able to access transition funds. Funds today are sometimes pooled together by staff members to assist transitioning residents with basic needs, such as bedding, towels, rent deposits etc.

The other services identified by the facilities largely align with the barriers discussed above and include:

- Increase in the number of Medicaid beds in existing or new alternative residential settings, including assisted living, group homes, ERCs and Adult Family Care⁴;
- Increase in the availability of subsidized senior housing;
- Increase in the size and viability of day care centers in the rural areas;
- Enhanced home modification funding;

³ Applies particularly, although not exclusively, to rural areas.

⁴ Enhanced federal funding under the MFP demonstration is restricted to placements with four or fewer beds. This would preclude the existing ERC option. However, it is included on the list in recognition that it would be a viable option for some MFP-eligible residents, even if the placement would be matched at the standard rate.

- More viable senior centers (possibly with help from the Dept of Aging), currently attendance is depressed due to lack of activities and classes;
- Increased community behavioral health service capacity;
- Enhanced transportation;
- Snow removal (in rural areas);
- Increase in the number of funded HCBS hours per person per week; and
- Increase in respite funding for weekend and evening respite.

The identified services range from the relatively simple (snow removal; additional respite capacity) to the very complex (expanding housing and behavioral health capacity). Looking to the future, DAIL likely would be able to address some barriers in the short term (within one year) while others will require several years of planning and implementation, in concert with other public and private sector stakeholders.

One key to success will be bringing the nursing facilities into the process as active partners, to the extent possible. In the interviews, facility representatives provided numerous examples of steps they say they have taken to facilitate the transition of residents who MFP criteria. For example, one facility spoke about working with Fletcher Allen to address the need for more community behavioral health capacity by arranging for psychologists to see patients in their community. Others pointed to the financial assistance provided to transitioning residents, as discussed above.

Ideally, the nursing facilities can be partners in building capacity to serve transitioning residents, thereby providing a financial incentive for their support. Facilities with excess capacity are often well suited to operate adult day care programs and institutional respite services. They also may have the appropriate infrastructure for developing assisted living and other residential placement alternatives for residents who can safely reside in a less supervised setting but are not good candidates for returning to a private home.

FINANCIAL ANALYSIS

PHPG conducted a preliminary analysis to estimate: 1) the total number of Vermont nursing home residents who meet MFP criteria and 2) the potential financial impact for the state if a portion of these residents transition back to the community. The analysis is intended to inform the decision making process for the demonstration grant application but should not be viewed as a precise calculation of the program's impact.

As a first step, PHPG estimated the number of MFP-eligible residents in Vermont nursing facilities by extrapolating from the data collected during the onsite interviews. The extrapolation was performed based on the portion of total Medicaid days represented by the eleven facilities in July 2010, the most recent month for which data was available.

As illustrated in Exhibit 3 below, the result is an estimated 100 MFP-eligible residents statewide.

Exhibit 3 – Estimate of Total MFP-Eligible Residents

Nursing Facility	Total Medicaid Census	Low Case Mix	Physically Disabled	Mild to Moderate Geriatric/Behavioral	Cognitive Impairment	Cognitive Impairment with TBI	Total
Onsite	717	27	4	2	5	1	39
All Other	1,128	42	6	3	8	2	61
Total Statewide	1,845	69	10	5	13	3	100

The potential annual financial impact of the MFP demonstration was calculated taking into consideration the average difference in per day expenditures between nursing facility residents and HCBS enrollees and the enhanced federal matching dollars available for qualifying HCBS services under the demonstration during their first year post-discharge.

More specifically, the analysis included the following components:

- The estimated number of MFP-eligible residents (100) was multiplied by 365 to calculate annual eligible resident days.
- It was assumed that one-half of the resident days would be converted to HCBS days under the demonstration.
- The average per day expenditures for institutional and HCBS were derived from data used to calculate the current PACE rates. The values were net of share-of-cost and included both acute and long-term care dollars (nursing facility cost equaled \$176.85; HCBS cost equaled \$92.02). An additional \$2,500 transition grant expenditure was included within the HCBS calculation⁵.
- Federal match for nursing facility and acute care expenditures was calculated using the current ARRA FMAP of 69.96 percent. Federal match for HCBS

⁵ This methodology was deemed reasonable for a high-level analysis of the relative cost of the nursing facility and HCBS populations. It is fair to note, however, that MFP-eligible residents could have a lower than average case mix as compared to the total nursing facility population and a higher than average case mix as compared to the total HCBS population. If so, the gap between nursing facility and HCBS per day costs could be smaller than represented in the analysis. This would have the effect of lowering, though not eliminating, the projected savings.

expenditures was calculated using the MFP-enhanced FMAP of 84.98 percent (it was assumed that all services would qualify for the enhanced match).

- No allocation was made for administrative costs (many of which would be reimbursable through the demonstration) or for potential savings attributable to diversion of potential new nursing facility admissions to HCBS (outside of MFP demonstration).

Exhibit 4 on the next page presents the results of the financial analysis. As it illustrates, estimated annual program savings exceed \$1.4 million, of which nearly \$600,000 would accrue to the state (note: savings are represented by negative dollar values).

ADDITIONAL CONSIDERATIONS

The feasibility analysis was limited to evaluating the potential size of the MFP-eligible population and the service expenditure savings associated with transitioning a portion of the population back to the community. However, the demonstration also would require additional administrative resources for implementation (e.g., drafting new regulations) and ongoing operations (e.g., staffing a unit with responsibility for undertaking transition activities). Many of the administrative expenditures would be fully reimbursable under the demonstration but still would require a lasting commitment from AHS and DAIL to ensure the success of what would be a multi-year effort.

At the same time, the demonstration's benefits would likely extend to more individuals than just the MFP-eligible population. By creating new service options, and expanding existing service capacity, the state would make available the option of community-based care to new long-term care beneficiaries who today are admitted to nursing facilities.

NEXT STEPS

If DAIL elects to move forward with the MFP application process, the next step must be to consult with the broader stakeholder community, including consumer, provider and other public representatives, on the demonstration design. Due to the limited time remaining, stakeholder outreach can occur parallel to early work on the draft application. The final version (or a decision not to pursue the demonstration) would await the findings of, and be informed by, the full stakeholder process.

Exhibit 3 – Estimate of MFP Annualized Financial Impact

Scenario	MFP-Eligible Pop.	Nursing Facility Residents					HCBS Enrollees (MFP Eligible Population)						Expenditures - NF + HCBS		
		Expenditures (FMAP = 69.96%)					Expenditures (HCBS MFP FMAP = 84.98%; all other = 69.96%)								
		Resident Days (12mo tenure)	Average Per Day Cost	State	Federal	Total Expend.	HCBS Days	Average Per Day Cost	Transition Grant per Resident	State	Federal	Total Expend.	State	Federal	Total Expend.
Current Program	100	36,500	\$ 176.85	\$ 1,939,105	\$ 4,515,971	\$ 6,455,076	-	-	-	-	-	\$ 1,939,105	\$ 4,515,971	\$ 6,455,076	
MFP Demonstration	100	18,250	\$ 176.85	\$ 969,552	\$ 2,257,986	\$ 3,227,538	18,250	\$ 92.02	\$ 2,500.00	\$ 374,526	\$ 1,429,866	\$ 1,804,392	\$ 1,344,078	\$ 3,687,852	\$ 5,031,930
Diff. (Demo - Current)		(18,250)		\$ (969,552)	\$ (2,257,986)	\$ (3,227,538)	18,250			\$ 374,526	\$ 1,429,866	\$ 1,804,392	\$ (595,026)	\$ (828,119)	\$ (1,423,146)

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp) _____
Action Taken _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____	OT Cat _____	EEO Cat _____ FLSA _____
New Mgt Level _____ B/U _____	OT Cat _____	EEO Cat _____ FLSA _____
Classification Analyst _____	Date _____	Effective Date _____
Comments _____		Date Processed _____
Willis Rating/Components: _____	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Accountability: _____
	Total: _____	

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Project Director
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671
Supervisor's Name, Title and Phone Number: Adele Edelman, Adult Services Unit Director 241-2402

Type of Request:

- Management:** A management request to review the classification of an existing position, class, or create a new job class.
- Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new position that will lead the development, implementation and management of a \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Main functions:

The Project Director will be responsible for leading the design, development, implementation, and plans for sustaining the MFP demonstration grant.

Reports to:

This position reports to the Adult Services Unit Director.

Duties:

- (What) Ensure operating procedures meet program goals.

(How) By providing adequate leadership and oversight of the program according to the CMS Terms and Conditions and approved Operational Protocol. Specific program benchmarks have been set and will be monitored by this position and reported to CMS. This position will supervise the program staff that will implement the operating procedures according to set protocol with the leadership needed to assure goals are being met. This position have frequent communication with federal CMS authorities who will monitor the state's compliance with the operating procedures.

(Why) To assure continued funding by CMS, to assure that the program is meeting it's set goals and to assure the needs of the people being served are met.

- (What) Oversees the program budget and ensures financial accountability.

(How) By taking the lead in the development and oversight of the project budget, supervising a Data Analyst responsible for performing data analysis, and working closely with the DAIL and AHS business offices and the Medicaid billing provider, Hewlett Packard (HP). This position will be responsible for assuring required financial reports are submitted to federal CMS authorities according to the required Terms and Conditions.

(Why) This project requires close monitoring of a pre-approved CMS budget with assigned

match rates. Maintaining appropriate financial accountability and required financial reports will help assure continued funding by CMS.

- (What) Responsible for overall quality and management of MFP program.

(How) By taking the lead in designing the quality management activities required of the grant and supervising two Quality Management Specialists responsible for assuring the health and welfare of people being served under this grant. Since the individuals served by this grant are frail and vulnerable, it is critical that the process of transitioning them out of a nursing home is done in a way that meets their needs and assures their continued health and welfare.

(Why) Quality management is a key requirement of the grant set forth by CMS. The health and welfare of the people served by this grant must be protected. By assuring the quality standards are met it will help assure continued funding by CMS.

- (What) Supervise program delivery.

(How) By supervising all staff assigned to the program, including an Administrative Assistant, three Transition Coordinators, one Data Analyst, two quality Management Specialists, and contracts for two Community Development Specialists and Transition Consultants. Also, by collaborating with community partners and stakeholders in the development and implementation process.

(Why) To assure full funding by CMS, this grant requires close supervision to assure CMS requirements for program delivery are met according to the CMS Terms and Conditions and Operational Protocol.

- (What) Hire personnel for program implementation.

(How) By taking the lead in arranging interviews, choosing candidates and submitting required state employment and hire forms. This position will also oversee training of new staff.

(Why) To develop and implement the program according to the CMS Terms and Conditions and Operational Protocol.

- (What) Recognize and solve potential problems and evaluate program effectiveness.

(How) By providing adequate leadership and oversight of the program. This position will be responsible for regular communication with all MFP staff, providers and stakeholders to identify problems as they arise.

(Why) To assure full funding by CMS and program effectiveness.

- (What) Perform quality functions.

(How) By supervising two Quality Management Specialists responsible for oversight of a 24/7 backup system, critical incident reporting system, risk mitigation, utilization review of care plans, and quality assessment and improvement evaluations.

(Why) To assure compliance with federal CMS Terms and Conditions, approved Operational Protocol and promote program improvement.

- (What) Provide program content expertise.

(How) By applying pre-existing skills and leadership to develop program knowledge and expertise. By providing technical assistance to staff and providers and to help problem-solve when issues arise.

(Why) To assure continued federal funding by maintaining compliance with federal CMS Terms and Conditions, approved Operational Protocol and to promote program

improvement.

- (What) Facilitate MFP Steering Committee meetings.

(How) By working with administrative assistant to coordinate meetings, creating agendas, invite members, facilitate discussions and follow-through and disseminate minutes.

(Why) To assure compliance with CMS Terms and Conditions, approved Operational Protocol and promote program quality and improvement.

- (What) Facilitate ad-hoc workgroups and forums.

(How) By working with the administrative assistant to coordinate workgroups and forums, invite members and facilitate discussions and follow-through regarding program management, quality assurance and improvement.

(Why) To assure compliance with CMS Terms and Conditions, approved Operational Protocol and promote program quality and improvement.

- (What) Address capacity issues as they arise.

(How) By working with community partners and stakeholders to identify capacity issues. Supervise Community Development specialist responsible for identifying housing alternatives. By working with contracted Transition Consultants to problem-solve capacity issues as they arise.

(Why) To assure adequate capacity to meet the needs of people being served in the community and to assure compliance with CMS Terms and Conditions, approved Operational Protocol and promote quality and program improvement.

- (What) Network with local, state and national agencies for future program development as required.

(How) By participating in meetings, forums and discussions as they arise. By maintaining frequent communication with federal CMS authorities and attend grant required national meetings and conferences.

(Why) To assure compliance with federal CMS Terms and Conditions, approved Operational Protocol and to promote quality, program improvement and successful outcomes for the people being served.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

-This position will report to and collaborate directly with the CMS federal office that oversees the grant for the purpose of technical assistance and compliance with the CMS Terms and Conditions and approve Operational Protocol.

-In addition, this position will facilitate meetings and workgroups that include provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, housing agencies, and transportation agencies for the purpose of program implementation, provision of services and quality assurance and improvement.

-This position will also collaborate with multiple state agencies during the development and implementation such as the Agency of Human Services (AHS) regarding financial reporting

and federal compliance, Department for Children and Families (DCF) regarding the financial eligibility and tracking process for people being served, Department of VT Health Access (DVHA) regarding Medicaid claims administration and tracking of people being served, and the Division of Licensing and Protection (DLP) regarding nursing home regulations, compliance and communication. This position will also collaborate with the state contracted Medicaid billing provider, Hewlett Packard (HP) for the purpose of claims processing and financial tracking/reporting.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- This position must have exceptional leadership skills and knowledge of long-term care systems and the issues facing people who are aging and people with disabilities.
- Extensive knowledge of and expertise in the theories and practice of interpersonal communication, group dynamics, change and project management. This includes leading working groups where strong differences of opinions may exist and the ability to find workable outcomes.
- Ability to negotiate and mediate areas of disagreement to build consensus within groups.
- Ability to work independently and set priorities among competing demands.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home- and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home- and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Considerable knowledge of the principles and practices of service and program planning, implementation, coordination, and evaluation.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Considerable knowledge of program planning and monitoring.
- Working knowledge of state and federal regulations.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Ability to present information and policy to the public and solicit the public's opinions.
- Ability to prepare detailed analyses of problem situations and implement practical and attainable solutions.

- Ability to develop consensus on issues, policies, and programs where strong differences of opinion exist.
- Ability to correctly interpret and apply regulations of considerable complexity.
- Ability to use Microsoft Word, Excel and Outlook and other database applications.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

Yes. It is anticipated that this position will supervise seven staff.

Positions to be requested:

- One half-time Administrative Assitant
- Three full-time Transition Coordinators
- One full-time Data Analyst
- Two full-time Quality Mangement Specialists

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the Adult Services Unit Director through regular attendance at management level meetings, supervisory meetings and data reports.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

- This position takes the lead responsibility in building a new \$23 million dollar grant program. This requires a high level of mental effort to juggle the multiple tasks required to start a new program, such as hiring and training new staff and implementing program

policies and procedures according to CMS requirements.

- The project has a large budget that must be monitored closely by this position and requires compliance with federal CMS Terms & Conditions and a CMS approved Operational Protocol. The federal requirements include multiple program and financial monitoring reports that must be submitted to CMS quarterly, bi-annually and annually. Non-compliance with the federal requirements set forth by CMS may result in the loss of grant funds. Additionally, since the program has a large budget, it will be monitored closely by AHS and the State of Vermont, placing added mental effort on this position.

- The goal of the grant is to help people who want to leave nursing homes to be able to leave and live in the community. There are currently some stakeholders who are not convinced that this is a good idea because they believe it may place people at risk of harm if they do not have the needed supports in the community and it may also result in reduced nursing home revenues. Therefore, not only must this position assure the health and welfare of the people it serves, it must maintain positive relationships with stakeholders and convince some reluctant partners why they should collaborate with the grant to help people transition out of nursing homes and into community-based settings.

- Mental effort for this position is high in all areas of planning, implementation and accountability.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Managing a \$23 million dollar budget over five years while properly accounting for services that have a specified enhanced federal match.
- Maintaining grant funding by assuring compliance with required federal CMS Terms & Conditions and approve Operational Protocol, including federal reporting requirements.
- Designing and implementing a new program that will identify people who have been in a nursing home for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community. The program will provide one-time funding to pay for currently un-reimbursed transitional supports (such as security deposits or equipment) in addition to finding approved housing for individuals without a place to live. Additionally, this grant plans to develop a new community housing alternative for people needing nursing home level of care called "Adult Family Care". The

purpose is to provide long-term care in small, family-like settings for people who would otherwise need care in a nursing home. Because the people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare with this grant.

- Helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose. The five-year program budget is approximately \$23 million total, with approximately \$18 million being federally funded. Federal funds include 100% administrative match and an enhanced Medicaid match for all home and community based services delivered in the first year after nursing home discharge.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
State-wide travel	estimated 25-30%
Interstate travel	estimated 2-3 times/year
This position has a very large budget and will be watched closely by State administrators, federal administrators and the public.	all of the time

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
none	

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
none		

- d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?

office/field work - meetings/ sitting, reaching, typing	estimate 80%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

none

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This is a new position that has not yet implemented supervision.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have exceptional leadership skills to manage multiple layers of program development and implementation of a new grant while working within existing long-term care systems and regulations. The employee in this position must foster and maintain a high level of professional relationships with multiple community providers, state and federal contacts. This employee must also have the ability work with stakeholders that may not agree or who may be reluctant to participate in the grant. Finally, this employee must have strong budget building and tracking skills to comply with federal grant requirements.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 25

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
 Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature **(required)**: _____, Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature **(required)**

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp) _____
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____	OT Cat: _____ EEO Cat: _____ FLSA _____	
New Mgt Level _____ B/U _____	OT Cat: _____ EEO Cat: _____ FLSA _____	
Classification Analyst _____	Date _____	Effective Date _____
Comments: _____		Date Processed: _____
Willis Rating/Components _____	Knowledge & Skills _____	Mental Demands _____
	Working Conditions _____	Accountability _____
	Total _____	

Incumbent Information:

Employee Name: Employee Number:

Position Number: Current Job/Class Title:

Agency/Department/Unit: Work Station: Zip Code:

Supervisor's Name, Title, and Phone Number:

How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Administrative Assistant

Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored

Vacant Position Number: N/A Current Job/Class Title: N/A

Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671

Supervisor's Name, Title and Phone Number: Program Director- TBD

Type of Request:

- Management:** A management request to review the classification of an existing position, class, or create a new job class.
- Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new half-time position that will provide administrative support to the Project Director for a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Duties:

(What) Provide administrative support to the Money Follows the Person (MFP) Program Director and workgroups.

(How)

- a. By assisting the Program Director to administratively organize the new MFP grant information, space, staff and files.
- b. By assisting the Program Director to arrange interviews for potential new MFP grant employees.
- c. By disseminating incoming mail to MFP staff and processing outgoing mail for the MFP program.
- d. By taking calls about the MFP grant program and directing them to the appropriate staff.
- e. By arranging meeting dates using Microsoft Outlook calendars.
- f. By finding space for meetings (internal and external) with staff, stakeholders, community partners and workgroups as requested.
- g. By creating meeting agendas and taking meeting minutes.
- h. By disseminating information internally or externally as requested.
- i. By finding space and setting up training for MFP staff.
- j. By photo copying, faxing and filing documents as needed.
- k. By typing and/or formatting documents in Microsoft Word as needed.
- l. By processing and disseminating program information and reports as needed.

- m. By processing MFP sub-recipient grants as needed.
 - n. By organizing and submitting staff time-sheets and expense sheets for the Program Director.
 - o. By sending emails to staff, stakeholders, community partners and workgroups as needed.
 - p. By organizing MFP events as needed.
 - q. By assisting the Project Director with travel requests and arrangements as needed.
 - r. By performing other administrative tasks as requested by the Program Director.
- (Why) To provide the necessary administrative support that is needed to help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical to assure continued grant funding.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

This position will report directly to the MFP Program Director who reports to the Commissioner.

This position provides the administrative support for coordinating meetings, workgroups, disseminating information and taking calls for the MFP grant. Therefore, it will have personal contact and interaction with provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, housing agencies, and transportation agencies.

This position will also have similar contact with State agencies such as the Agency of Human Services (AHS), Department for Children and Families (DCF), Department of VT Health Access (DVHA), the Division of Licensing and Protection (DLP) and the state contracted Medicaid billing provider, Hewlett Packard (HP).

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Typing skills
- Microsoft Word and Outlook experience
- Ability to operate copy and fax machines
- Good telephone communication skills

- Good organizational skills
- Good interpersonal skills

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAIL Commissioner. The Program Director will assign work on a daily and/or weekly basis and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

This is a new grant program that is currently under development. This position will be responsible for providing support to the Program Director through multiple developmental stages of the grant. This can be very stressfull because of the many layers of responsibilities that lay ahead. This position will be part-time which means it must prioritize responsibilities in order to maintain administrative efficiency for the grant.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Organizing and supporting administrative functions to the Program Director of a new \$23 million dollar federal grant.
- Assisting the Program Director by providing administrative support that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Assisting the Program Director by performing administrative functions that will directly assist in implementing a new program that will identify people who have been in a nursing home for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community. The program will provide one-time funding to pay for currently un-reimbursed transitional supports (such as security deposits or equipment) in addition to finding approved housing for individuals without a place to live. Additionally, this grant plans to develop a new community housing alternative for people needing nursing home level of care called "Adult Family Care". The purpose is to provide long-term care in small, family-like settings for people who would otherwise need care in a nursing home. Because the people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare with this grant.
- Assisting the Program Director in performing administrative functions that will assist in helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
No "significant" mental stress that "stands out".	

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
None	

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
None		

- d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
Sitting at a desk	85%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

N/A

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: The Program Director will be supervising this position and has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have exceptional organizational skills to help the Program Director administratively stay on track through the development and implementation of the new MFP grant program. This position must be able to function independently and have the ability to identify priorities and act on administrative needs without specific direction from the Program Director.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay Grade 19

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

**STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form**



This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report must be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/DAIL Date: 4/8/11

Name and Phone (of the person completing this request): Megan Tierney-Ward 241-2426

Request is for:

- Positions funded and attached to a new grant.
- Positions funded and attached to an existing grant approved by JFO # _____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

US Dept. of Health & Human Services, Centers for Medicare and Medicaid Services
"Money Follows the Person Demonstration Grant"
Cat No. #93.791

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested # of Positions Division/Program Grant Funding Period/Anticipated End Date

Project Director = 1, Administrative Assistant = ¹⁰3, Nurse Case Manager (aka Transition Coordinator) = 3, Quality Management Specialist = 2, Aging and Disabilities System Developer (aka Data Analyst) = 1

All positions will be in DAIL/DDAS. Grant period is 4/1/11-3/31/16 for all positions. They are 100% federally funded.

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

The purpose of the grant is to provide people living in nursing facilities the opportunity to live in the community with the services and supports they need. Over the next five years, it is anticipated that this grant will help approximately 375 adult Vermonters who have been living in a nursing facility for at least 90 days with VT Medicaid payment, and wish to leave the nursing facility but have been unable to do so because of a barrier to living in the community.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b)).

Susan Wettrick _____ Date 4/11/11
Signature of Agency or Department Head

Molly Pauley _____ Date 5/18/11
Approved/Denied by Department of Human Resources

Susan A. Zeller _____ Date 5/19/11
Approved/Denied by Finance and Management

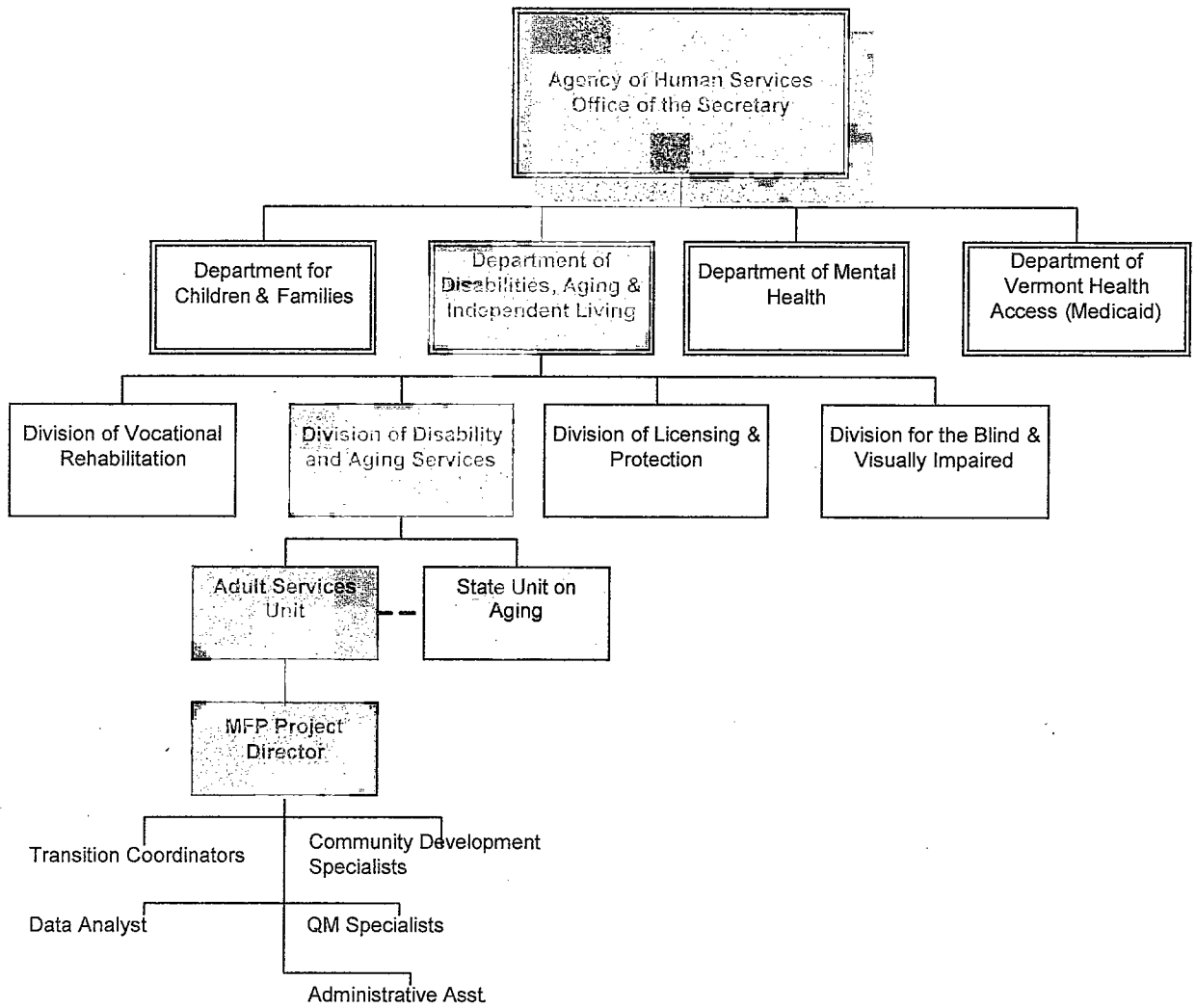
[Signature] _____ Date 5/19/11
Approved/Denied by Secretary of Administration

Comments:

[Faint handwritten text, possibly a signature or name]

[Faint handwritten text]

RECEIVED
MAY 18 2011
Bureau of Land Management
Department of the Interior



VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp) _____
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____ OT Cat. _____	EEO Cat. _____	FLSA _____
New Mgt Level _____ B/U _____ OT Cat. _____	EEO Cat. _____	FLSA _____
Classification Analyst _____	Date _____	Effective Date: _____
Comments: _____		Date Processed: _____
Willis Rating/Components:	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Total: _____
	Accountability: _____	

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Project Director
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671
Supervisor's Name, Title and Phone Number: Adele Edelman, Adult Services Unit Director 241-2402

Type of Request:

- Management:** A management request to review the classification of an existing position, class, or create a new job class.
- Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new position that will lead the development, implementation and management of a \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Main functions:

The Project Director will be responsible for leading the design, development, implementation, and plans for sustaining the MFP demonstration grant.

Reports to:

This position reports to the Adult Services Unit Director.

Duties:

- (What) Ensure operating procedures meet program goals.

(How) By providing adequate leadership and oversight of the program according to the CMS Terms and Conditions and approved Operational Protocol. Specific program benchmarks have been set and will be monitored by this position and reported to CMS. This position will supervise the program staff that will implement the operating procedures according to set protocol with the leadership needed to assure goals are being met. This position have frequent communication with federal CMS authorities who will monitor the state's compliance with the operating procedures.

(Why) To assure continued funding by CMS, to assure that the program is meeting it's set goals and to assure the needs of the people being served are met.

- (What) Oversees the program budget and ensures financial accountability.

(How) By taking the lead in the development and oversight of the project budget, supervising a Data Analyst responsible for performing data analysis, and working closely with the DAAIL and AHS business offices and the Medicaid billing provider, Hewlett Packard (HP). This position will be responsible for assuring required financial reports are submitted to federal CMS authorities according to the required Terms and Conditions.

(Why) This project requires close monitoring of a pre-approved CMS budget with assigned

match rates. Maintaining appropriate financial accountability and required financial reports will help assure continued funding by CMS.

•□(What) Responsible for overall quality and management of MFP program.

(How) By taking the lead in designing the quality management activities required of the grant and supervising two Quality Management Specialists responsible for assuring the health and welfare of people being served under this grant. Since the individuals served by this grant are frail and vulnerable, it is critical that the process of transitioning them out of a nursing home is done in a way that meets their needs and assures their continued health and welfare.

(Why) Quality management is a key requirement of the grant set forth by CMS. The health and welfare of the people served by this grant must be protected. By assuring the quality standards are met it will help assure continued funding by CMS.

•□(What) Supervise program delivery.

(How) By supervising all staff assigned to the program, including an Administrative Assistant, three Transition Coordinators, one Data Analyst, two quality Management Specialists, and contracts for two Community Development Specialists and Transition Consultants. Also, by collaborating with community partners and stakeholders in the development and implementation process.

(Why) To assure full funding by CMS, this grant requires close supervision to assure CMS requirements for program delivery are met according to the CMS Terms and Conditions and Operational Protocol.

•□(What) Hire personnel for program implementation.

(How) By taking the lead in arranging interviews, choosing candidates and submitting required state employment and hire forms. This position will also oversee training of new staff.

(Why) To develop and implement the program according to the CMS Terms and Conditions and Operational Protocol.

•□(What) Recognize and solve potential problems and evaluate program effectiveness.

(How) By providing adequate leadership and oversight of the program. This position will be responsible for regular communication with all MFP staff, providers and stakeholders to identify problems as they arise.

(Why) To assure full funding by CMS and program effectiveness.

•□(What) Perform quality functions.

(How) By supervising two Quality Management Specialists responsible for oversight of a 24/7 backup system, critical incident reporting system, risk mitigation, utilization review of care plans, and quality assessment and improvement evaluations.

(Why) To assure compliance with federal CMS Terms and Conditions, approved Operational Protocol and promote program improvement.

•□(What) Provide program content expertise.

(How) By applying pre-existing skills and leadership to develop program knowledge and expertise. By providing technical assistance to staff and providers and to help problem-solve when issues arise.

(Why) To assure continued federal funding by maintaining compliance with federal CMS Terms and Conditions, approved Operational Protocol and to promote program

improvement.

- (What) Facilitate MFP Steering Committee meetings.

(How) By working with administrative assistant to coordinate meetings, creating agendas, invite members, facilitate discussions and follow-through and disseminate minutes.

(Why) To assure compliance with CMS Terms and Conditions, approved Operational Protocol and promote program quality and improvement.

- (What) Facilitate ad-hoc workgroups and forums.

(How) By working with the administrative assistant to coordinate workgroups and forums, invite members and facilitate discussions and follow-through regarding program management, quality assurance and improvement.

(Why) To assure compliance with CMS Terms and Conditions, approved Operational Protocol and promote program quality and improvement.

- (What) Address capacity issues as they arise.

(How) By working with community partners and stakeholders to identify capacity issues. Supervise Community Development specialist responsible for identifying housing alternatives. By working with contracted Transition Consultants to problem-solve capacity issues as they arise.

(Why) To assure adequate capacity to meet the needs of people being served in the community and to assure compliance with CMS Terms and Conditions, approved Operational Protocol and promote quality and program improvement.

- (What) Network with local, state and national agencies for future program development as required.

(How) By participating in meetings, forums and discussions as they arise. By maintaining frequent communication with federal CMS authorities and attend grant required national meetings and conferences.

(Why) To assure compliance with federal CMS Terms and Conditions, approved Operational Protocol and to promote quality, program improvement and successful outcomes for the people being served.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

-This position will report to and collaborate directly with the CMS federal office that oversees the grant for the purpose of technical assistance and compliance with the CMS Terms and Conditions and approve Operational Protocol.

-In addition, this position will facilitate meetings and workgroups that include provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, housing agencies, and transportation agencies for the purpose of program implementation, provision of services and quality assurance and improvement.

-This position will also collaborate with multiple state agencies during the development and implementation such as the Agency of Human Services (AHS) regarding financial reporting

and federal compliance, Department for Children and Families (DCF) regarding the financial eligibility and tracking process for people being served, Department of VT Health Access (DVHA) regarding Medicaid claims administration and tracking of people being served, and the Division of Licensing and Protection (DLP) regarding nursing home regulations, compliance and communication. This position will also collaborate with the state contracted Medicaid billing provider, Hewlett Packard (HP) for the purpose of claims processing and financial tracking/reporting.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- This position must have exceptional leadership skills and knowledge of long-term care systems and the issues facing people who are aging and people with disabilities.
- Extensive knowledge of and expertise in the theories and practice of interpersonal communication, group dynamics, change and project management. This includes leading working groups where strong differences of opinions may exist and the ability to find workable outcomes.
- Ability to negotiate and mediate areas of disagreement to build consensus within groups.
- Ability to work independently and set priorities among competing demands.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home- and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home- and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Considerable knowledge of the principles and practices of service and program planning, implementation, coordination, and evaluation.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Considerable knowledge of program planning and monitoring.
- Working knowledge of state and federal regulations.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Ability to present information and policy to the public and solicit the public's opinions.
- Ability to prepare detailed analyses of problem situations and implement practical and attainable solutions.

- Ability to develop consensus on issues, policies, and programs where strong differences of opinion exist.
- Ability to correctly interpret and apply regulations of considerable complexity.
- Ability to use Microsoft Word, Excel and Outlook and other database applications.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

Yes. It is anticipated that this position will supervise seven staff.

Positions to be requested:

- One half-time Administrative Assitant
- Three full-time Transition Coordinators
- One full-time Data Analyst
- Two full-time Quality Mangement Specialists

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the Adult Services Unit Director through regular attendance at management level meetings, supervisory meetings and data reports.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

- This position takes the lead responsibility in building a new \$23 million dollar grant program. This requires a high level of mental effort to juggle the multiple tasks required to start a new program, such as hiring and training new staff and implementing program

policies and procedures according to CMS requirements.

- The project has a large budget that must be monitored closely by this position and requires compliance with federal CMS Terms & Conditions and a CMS approved Operational Protocol. The federal requirements include multiple program and financial monitoring reports that must be submitted to CMS quarterly, bi-annually and annually. Non-compliance with the federal requirements set forth by CMS may result in the loss of grant funds. Additionally, since the program has a large budget, it will be monitored closely by AHS and the State of Vermont, placing added mental effort on this position.

- The goal of the grant is to help people who want to leave nursing homes to be able to leave and live in the community. There are currently some stakeholders who are not convinced that this is a good idea because they believe it may place people at risk of harm if they do not have the needed supports in the community and it may also result in reduced nursing home revenues. Therefore, not only must this position assure the health and welfare of the people it serves, it must maintain positive relationships with stakeholders and convince some reluctant partners why they should collaborate with the grant to help people transition out of nursing homes and into community-based settings.

- Mental effort for this position is high in all areas of planning, implementation and accountability.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Managing a \$23 million dollar budget over five years while properly accounting for services that have a specified enhanced federal match.

- Maintaining grant funding by assuring compliance with required federal CMS Terms & Conditions and approve Operational Protocol, including federal reporting requirements.

- Designing and implementing a new program that will identify people who have been in a nursing home for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community. The program will provide one-time funding to pay for currently un-reimbursed transitional supports (such as security deposits or equipment) in addition to finding approved housing for individuals without a place to live. Additionally, this grant plans to develop a new community housing alternative for people needing nursing home level of care called "Adult Family Care". The

purpose is to provide long-term care in small, family-like settings for people who would otherwise need care in a nursing home. Because the people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare with this grant.

- Helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose. The five-year program budget is approximately \$23 million total, with approximately \$18 million being federally funded. Federal funds include 100% administrative match and an enhanced Medicaid match for all home and community based services delivered in the first year after nursing home discharge.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
State-wide travel	estimated 25-30%
Interstate travel	estimated 2-3 times/year
This position has a very large budget and will be watched closely by State administrators, federal administrators and the public.	all of the time

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
none	

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
none		

- d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?

office/field work - meetings/ sitting, reaching, typing	estimate 80%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

none

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This is a new position that has not yet implemented supervision.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have exceptional leadership skills to manage multiple layers of program development and implementation of a new grant while working within existing long-term care systems and regulations. The employee in this position must foster and maintain a high level of professional relationships with multiple community providers, state and federal contacts. This employee must also have the ability work with stakeholders that may not agree or who may be reluctant to participate in the grant. Finally, this employee must have strong budget building and tracking skills to comply with federal grant requirements.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 25

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
 Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____, Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

VERMONT DEPARTMENT OF PERSONNEL
**Request for Classification Review
Position Description Form A**

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
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Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp) _____
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
New Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
Classification Analyst _____	Date _____	Effective Date: _____
Comments: _____		Date Processed: _____
Willis Rating/Components: _____	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Accountability: _____
	Total: _____	

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Administrative Assistant
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671
Supervisor's Name, Title and Phone Number: Program Director- TBD

Type of Request:

- Management:** A management request to review the classification of an existing position, class, or create a new job class.
- Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new half-time position that will provide administrative support to the Project Director for a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Duties:

(What) Provide administrative support to the Money Follows the Person (MFP) Program Director and workgroups.

(How)

- a. By assisting the Program Director to administratively organize the new MFP grant information, space, staff and files.
- b. By assisting the Program Director to arrange interviews for potential new MFP grant employees.
- c. By disseminating incoming mail to MFP staff and processing outgoing mail for the MFP program.
- d. By taking calls about the MFP grant program and directing them to the appropriate staff.
- e. By arranging meeting dates using Microsoft Outlook calendars.
- f. By finding space for meetings (internal and external) with staff, stakeholders, community partners and workgroups as requested.
- g. By creating meeting agendas and taking meeting minutes.
- h. By disseminating information internally or externally as requested.
- i. By finding space and setting up training for MFP staff.
- j. By photo copying, faxing and filing documents as needed.
- k. By typing and/or formatting documents in Microsoft Word as needed.
- l. By processing and disseminating program information and reports as needed.

- m. By processing MFP sub-recipient grants as needed.
 - n. By organizing and submitting staff time-sheets and expense sheets for the Program Director.
 - o. By sending emails to staff, stakeholders, community partners and workgroups as needed.
 - p. By organizing MFP events as needed.
 - q. By assisting the Project Director with travel requests and arrangements as needed.
 - r. By performing other administrative tasks as requested by the Program Director.
- (Why) To provide the necessary administrative support that is needed to help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical to assure continued grant funding.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

This position will report directly to the MFP Program Director who reports to the Commissioner.

This position provides the administrative support for coordinating meetings, workgroups, disseminating information and taking calls for the MFP grant. Therefore, it will have personal contact and interaction with provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, housing agencies, and transportation agencies.

This position will also have similar contact with State agencies such as the Agency of Human Services (AHS), Department for Children and Families (DCF), Department of VT Health Access (DVHA), the Division of Licensing and Protection (DLP) and the state contracted Medicaid billing provider, Hewlett Packard (HP).

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Typing skills
- Microsoft Word and Outlook experience
- Ability to operate copy and fax machines
- Good telephone communication skills

- Good organizational skills
- Good interpersonal skills

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAII Commissioner. The Program Director will assign work on a daily and/or weekly basis and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

This is a new grant program that is currently under development. This position will be responsible for providing support to the Program Director through multiple developmental stages of the grant. This can be very stressful because of the many layers of responsibilities that lay ahead. This position will be part-time which means it must prioritize responsibilities in order to maintain administrative efficiency for the grant.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Organizing and supporting administrative functions to the Program Director of a new \$23 million dollar federal grant.
- Assisting the Program Director by providing administrative support that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Assisting the Program Director by performing administrative functions that will directly assist in implementing a new program that will identify people who have been in a nursing home for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community. The program will provide one-time funding to pay for currently un-reimbursed transitional supports (such as security deposits or equipment) in addition to finding approved housing for individuals without a place to live. Additionally, this grant plans to develop a new community housing alternative for people needing nursing home level of care called "Adult Family Care". The purpose is to provide long-term care in small, family-like settings for people who would otherwise need care in a nursing home. Because the people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare with this grant.
- Assisting the Program Director in performing administrative functions that will assist in helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
No "significant" mental stress that "stands out".	

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
None	

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
None		

- d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
Sitting at a desk	85%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

N/A

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: The Program Director will be supervising this position and has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have exceptional organizational skills to help the Program Director administratively stay on track through the development and implementation of the new MFP grant program. This position must be able to function independently and have the ability to identify priorities and act on administrative needs without specific direction from the Program Director.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay Grade 19

Supervisor's Signature (**required**): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

Kelly, Bill

From: McCaffrey, Marybeth
Sent: Monday, April 11, 2011 2:38 PM
To: Kelly, Bill
Cc: Tierney-Ward, Megan; Edelman, Adele; George, Camille
Subject: RE: MFP AA-1 Question

You are right, Bill. 3 Nurse Case Managers will be on the road most of the time.

These offices are available:

1. Room next to 250 (small, next to Jackie Rogers' office)
2. Room 244 (System's developer empty office)
3. Room 240 (empty office – fits 2 people)
4. Room 238 (empty office)
5. Room 237 (office we've used for temporary employees)
6. Room 230 (Camille's office)
7. Room next to 231 (small, next to Ellen Malone's office)

Another option is to free up David's current space and fit it for 3 or 4 temporary staff (nurses on the road, DDAS staff here in Waterbury for the day, etc.)

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____	Date Received (Stamp) _____
Action Taken: _____	
New Job Title _____	
Current Class Code _____	New Class Code _____
Current Pay Grade _____	New Pay Grade _____
Current Mgt Level _____ B/U _____ OT Cat. _____	EEO Cat. _____ FLSA _____
New Mgt Level _____ B/U _____ OT Cat. _____	EEO Cat. _____ FLSA _____
Classification Analyst _____	Date _____ Effective Date: _____
Comments: _____	Date Processed: _____
Willis Rating/Components: Knowledge & Skills: _____	Mental Demands: _____ Accountability: _____
Working Conditions: _____	Total: _____

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, US Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Nurse Case Manager AC: Long-Term Care
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671
Supervisor's Name, Title and Phone Number: Program Director- TBD

Type of Request:

Management: A management request to review the classification of an existing position, class, or create a new job class.

Employee: An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new full-time position to a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Duties:

1. **(What)** Make visits to nursing facilities across the state to screen, assess and identify individuals eligible for the MFP grant.

(How) By having regular email and phone communication with nursing facilities around the state and driving to the nursing facilities to participate in meetings with staff and residents to help identify people who may be eligible for MFP grant. By accurately assessing an individual's clinical eligibility for the Choices for Care and grant program.

(Why) To assure individuals indentified meet grant criteria and continued eligibility for the Choices for Care program so they can continue to receive long-term care services in the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

2. **(What)** Respond to MFP referrals from nursing facilities, residents, families, guardians and others; undertaking comprehensive transition planning at least 90 days prior to discharge.

(How) By following a designated protocol for receiving referrals and being available by email and phone. By driving to nursing facilities statewide to meet with staff, case managers, individuals and families to complete all required discharge planning and grant paperwork while tracking the 90-day transition time-frame.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

3. **(What)** Performing transition assessments (including a comprehensive risk assessment)

and develop individualized plans of care in collaboration with the individual and assigned case manager.

(How) By traveling to nursing facilities statewide to meet with staff, case managers, individuals and families. By performing required assessments, identifying the health, clinical, social, financial and environmental needs for supports and services, and completing all required paperwork. By working collaboratively with stakeholders.

(Why) To identify the individual's eligibility for grant funds, need for services and to assure the individual's continued health and welfare is met after transition to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

4. (What) Collaborate with the participant's case manager and Community Development Specialist to arrange and coordinate services pre-transition.

(How) By contacting by email or phone, the individual's case manager and Community Development Specialist (as needed) to include them in pre-transition planning meetings. By communicating by phone or email on a regular basis with the case manager and Community Development Specialist as needed to discuss the individual's discharge plan.

(Why) To assure that the individual has a successful transition from the nursing home to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

5. (What) Perform discharge planning functions in coordination with the nursing facility and carrying out post-transition follow-up calls and visits as necessary to ensure implementation of the plan of care and to identify any unmet needs that could pose a risk of re-institutionalization.

(How) By having regular email and/or phone communication with the nursing facility and participating in on-site meetings at the nursing facility as needed. By traveling to the individual's new home in the community to monitor the services being provided. By contacting the individual by phone and communicating with the individual's case manager on a regular basis. By communicating with Choices for Care service providers as needed.

(Why) To assure a successful transition to the community for the individual. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

6. Perform other duties as assigned.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

-This position will report directly to the MFP Program Director who reports to the Commissioner.

-This position is responsible for identifying eligible individuals and coordinating transitions to

the community and monitoring services after discharge from the nursing facility. Therefore, this position must have personal contact and interaction with multiple provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, Adult Day providers, housing agencies, and transportation agencies.

-This position will also have similar contact with State agencies such as the Department for Children and Families (DCF) regarding public benefits and Choices for Care eligibility, and the Division of Licensing and Protection (DLP) for regulatory issues and matters of adult abuse, neglect and exploitation. This position will also have direct contact with the Office of Public guardian when an individual has been appointed a public guardian and the local DAIL Long-Term Care clinical coordinator regarding clinical eligibility and coordination of services.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Registered Nurse license with the State of Vermont
- Good assessment skills
- Ability to work independently and set priorities among competing demands.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Ability to use Microsoft Word, Outlook and other database applications as needed.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAHL Commissioner. This position will independently schedule work based on the volume of referrals and scheduled outreach to nursing facilities and providers. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

This is a new grant program that is currently under development. This position will be responsible for coordinating transitions for people who want to leave nursing facilities and for arranging the services that will meet their need once in the community. Because of their higher level of reliance on personal care services and supports, the individuals participating in this grant are at greater risk of harm if services are not provided and monitored closely. In addition, there may be situations in which an individual wants to leave a nursing facility but other providers, family or nursing facility staff do not agree with this choice. The Transition Coordinator must be able to work collaboratively with people who may not agree while maintaining the individual's right to choose and at the same time assuring their health and welfare. This can be very stressfull because of the many layers of responsibility to the individual, stakeholders and the grant requirements.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Performing key work tasks for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, identifying an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Perform accurate assessments that identify an individual's needs and develop care plans that will adequately meet their needs once they transition out of the nursing facility.
- Assuring successful transitions from the nursing facility to the community. Because people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare.
- Performing work tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Working with providers and/or families who may not agree with an individual's decision to leave the nursing facility.	estimate 30%
Must assure the continued health and welfare of potentially "at risk" individuals after leaving the nursing facility.	100%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
None	

c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
None		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
Sitting at a desk	estimate 30%
office/field work - meetings/ sitting, reaching, typing	estimate 80%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Project Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this employee have excellent assessment skills to identify the health, clinical, social, financial and environmental needs of people in need of long-term care services. This employee must have the skills to identify the barriers keeping people from being able to leave nursing homes and the ability to create, review and monitor care plans for people in need of long-term care services. This employee must have existing knowledge of the systems that affect people who are aging and/or are living with a disability, including community-based long-term care. This position must also have the ability to develop trust and good working relationships with multiple stakeholders, families and people living in nursing homes.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 24.

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp) _____
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
New Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
Classification Analyst _____	Date _____	Effective Date: _____
Comments: _____		Date Processed: _____
Willis Rating/Components: _____	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Accountability: _____
	Total: _____	

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, US Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Nurse Case Manager AC: Long-Term Care
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671
Supervisor's Name, Title and Phone Number: Program Director- TBD

Type of Request:

Management: A management request to review the classification of an existing position, class, or create a new job class.

Employee: An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** Audits tax returns and/or taxpayer records. **(How)** By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency. **(Why)** To determine actual tax liabilities.

Intro:

This request is for a new full-time position to a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Duties:

1. (What) Make visits to nursing facilities across the state to screen, assess and identify individuals eligible for the MFP grant.

(How) By having regular email and phone communication with nursing facilities around the state and driving to the nursing facilities to participate in meetings with staff and residents to help identify people who may be eligible for MFP grant. By accurately assessing an individual's clinical eligibility for the Choices for Care and grant program.

(Why) To assure individuals indentified meet grant criteria and continued eligibility for the Choices for Care program so they can continue to receive long-term care services in the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

2. (What) Respond to MFP referrals from nursing facilities, residents, families, guardians and others; undertaking comprehensive transition planning at least 90 days prior to discharge.

(How) By following a designated protocol for receiving referrals and being available by email and phone. By driving to nursing facilities statewide to meet with staff, case managers, individuals and families to complete all required discharge planning and grant paperwork while tracking the 90-day transition time-frame.

(Why)To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

3. (What) Performing transition assessments (including a comprehensive risk assessment)

and develop individualized plans of care in collaboration with the individual and assigned case manager.

(How) By traveling to nursing facilities statewide to meet with staff, case managers, individuals and families. By performing required assessments, identifying the health, clinical, social, financial and environmental needs for supports and services, and completing all required paperwork. By working collaboratively with stakeholders.

(Why) To identify the individual's eligibility for grant funds, need for services and to assure the individual's continued health and welfare is met after transition to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

4. (What) Collaborate with the participant's case manager and Community Development Specialist to arrange and coordinate services pre-transition.

(How) By contacting by email or phone, the individual's case manager and Community Development Specialist (as needed) to include them in pre-transition planning meetings. By communicating by phone or email on a regular basis with the case manager and Community Development Specialist as needed to discuss the individual's discharge plan.

(Why) To assure that the individual has a successful transition from the nursing home to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

5. (What) Perform discharge planning functions in coordination with the nursing facility and carrying out post-transition follow-up calls and visits as necessary to ensure implementation of the plan of care and to identify any unmet needs that could pose a risk of re-institutionalization.

(How) By having regular email and/or phone communication with the nursing facility and participating in on-site meetings at the nursing facility as needed. By traveling to the individual's new home in the community to monitor the services being provided. By contacting the individual by phone and communicating with the individual's case manager on a regular basis. By communicating with Choices for Care service providers as needed.

(Why) To assure a successful transition to the community for the individual. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

6. Perform other duties as assigned.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

-This position will report directly to the MFP Program Director who reports to the Commissioner.

-This position is responsible for identifying eligible individuals and coordinating transitions to

the community and monitoring services after discharge from the nursing facility. Therefore, this position must have personal contact and interaction with multiple provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, Adult Day providers, housing agencies, and transportation agencies.

-This position will also have similar contact with State agencies such as the Department for Children and Families (DCF) regarding public benefits and Choices for Care eligibility, and the Division of Licensing and Protection (DLP) for regulatory issues and matters of adult abuse, neglect and exploitation. This position will also have direct contact with the Office of Public guardian when an individual has been appointed a public guardian and the local DAIL Long-Term Care clinical coordinator regarding clinical eligibility and coordination of services.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Registered Nurse license with the State of Vermont
- Good assessment skills
- Ability to work independently and set priorities among competing demands.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Ability to use Microsoft Word, Outlook and other database applications as needed.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAHL Commissioner. This position will independently schedule work based on the volume of referrals and scheduled outreach to nursing facilities and providers. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

This is a new grant program that is currently under development. This position will be responsible for coordinating transitions for people who want to leave nursing facilities and for arranging the services that will meet their need once in the community. Because of their higher level of reliance on personal care services and supports, the individuals participating in this grant are at greater risk of harm if services are not provided and monitored closely. In addition, there may be situations in which an individual wants to leave a nursing facility but other providers, family or nursing facility staff do not agree with this choice. The Transition Coordinator must be able to work collaboratively with people who may not agree while maintaining the individual's right to choose and at the same time assuring their health and welfare. This can be very stressfull because of the many layers of responsibility to the individual, stakeholders and the grant requirements.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Performing key work tasks for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, identifying an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Perform accurate assessments that identify an individual's needs and develop care plans that will adequately meet their needs once they transition out of the nursing facility.
- Assuring successful transitions from the nursing facility to the community. Because people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare.
- Performing work tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Working with providers and/or families who may not agree with an individual's decision to leave the nursing facility.	estimate 30%
Must assure the continued health and welfare of potentially "at risk" individuals after leaving the nursing facility.	100%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
None	

c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
None		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
Sitting at a desk	estimate 30%
office/field work - meetings/ sitting, reaching, typing	estimate 80%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Project Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this employee have excellent assessment skills to identify the health, clinical, social, financial and environmental needs of people in need of long-term care services. This employee must have the skills to identify the barriers keeping people from being able to leave nursing homes and the ability to create, review and monitor care plans for people in need of long-term care services. This employee must have existing knowledge of the systems that affect people who are aging and/or are living with a disability, including community-based long-term care. This position must also have the ability to develop trust and good working relationships with multiple stakeholders, families and people living in nursing homes.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 24.

Supervisor's Signature (**required**): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

Organizational charts are **required** and must indicate where the position reports.

Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
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To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

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If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp)
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
New Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
Classification Analyst _____	Date _____	Effective Date: _____
Comments: _____		Date Processed: _____
Willis Rating/Components: _____	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Accountability: _____
	Total: _____	

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, US Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Nurse Case Manager AC: Long-Term Care
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671
Supervisor's Name, Title and Phone Number: Program Director- TBD

Type of Request:

Management: A management request to review the classification of an existing position, class, or create a new job class.

Employee: An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

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Intro:

This request is for a new full-time position to a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

Duties:

1. (What) Make visits to nursing facilities across the state to screen, assess and identify individuals eligible for the MFP grant.

(How) By having regular email and phone communication with nursing facilities around the state and driving to the nursing facilities to participate in meetings with staff and residents to help identify people who may be eligible for MFP grant. By accurately assessing an individual's clinical eligibility for the Choices for Care and grant program.

(Why) To assure individuals identified meet grant criteria and continued eligibility for the Choices for Care program so they can continue to receive long-term care services in the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

2. (What) Respond to MFP referrals from nursing facilities, residents, families, guardians and others; undertaking comprehensive transition planning at least 90 days prior to discharge.

(How) By following a designated protocol for receiving referrals and being available by email and phone. By driving to nursing facilities statewide to meet with staff, case managers, individuals and families to complete all required discharge planning and grant paperwork while tracking the 90-day transition time-frame.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

3. (What) Performing transition assessments (including a comprehensive risk assessment)

and develop individualized plans of care in collaboration with the individual and assigned case manager.

(How) By traveling to nursing facilities statewide to meet with staff, case managers, individuals and families. By performing required assessments, identifying the health, clinical, social, financial and environmental needs for supports and services, and completing all required paperwork. By working collaboratively with stakeholders.

(Why) To identify the individual's eligibility for grant funds, need for services and to assure the individual's continued health and welfare is met after transition to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

4. (What) Collaborate with the participant's case manager and Community Development Specialist to arrange and coordinate services pre-transition.

(How) By contacting by email or phone, the individual's case manager and Community Development Specialist (as needed) to include them in pre-transition planning meetings. By communicating by phone or email on a regular basis with the case manager and Community Development Specialist as needed to discuss the individual's discharge plan.

(Why) To assure that the individual has a successful transition from the nursing home to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

5. (What) Perform discharge planning functions in coordination with the nursing facility and carrying out post-transition follow-up calls and visits as necessary to ensure implementation of the plan of care and to identify any unmet needs that could pose a risk of re-institutionalization.

(How) By having regular email and/or phone communication with the nursing facility and participating in on-site meetings at the nursing facility as needed. By traveling to the individual's new home in the community to monitor the services being provided. By contacting the individual by phone and communicating with the individual's case manager on a regular basis. By communicating with Choices for Care service providers as needed.

(Why) To assure a successful transition to the community for the individual. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. This is critical in assuring that the program goals are met and grant funding is continued.

6. Perform other duties as assigned.

2. Key Contacts

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-This position is responsible for identifying eligible individuals and coordinating transitions to

the community and monitoring services after discharge from the nursing facility. Therefore, this position must have personal contact and interaction with multiple provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, Adult Day providers, housing agencies, and transportation agencies.

-This position will also have similar contact with State agencies such as the Department for Children and Families (DCF) regarding public benefits and Choices for Care eligibility, and the Division of Licensing and Protection (DLP) for regulatory issues and matters of adult abuse, neglect and exploitation. This position will also have direct contact with the Office of Public guardian when an individual has been appointed a public guardian and the local DAIL Long-Term Care clinical coordinator regarding clinical eligibility and coordination of services.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Registered Nurse license with the State of Vermont
- Good assessment skills
- Ability to work independently and set priorities among competing demands.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Ability to use Microsoft Word, Outlook and other database applications as needed.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAIL Commissioner. This position will independently schedule work based on the volume of referrals and scheduled outreach to nursing facilities and providers. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

This is a new grant program that is currently under development. This position will be responsible for coordinating transitions for people who want to leave nursing facilities and for arranging the services that will meet their need once in the community. Because of their higher level of reliance on personal care services and supports, the individuals participating in this grant are at greater risk of harm if services are not provided and monitored closely. In addition, there may be situations in which an individual wants to leave a nursing facility but other providers, family or nursing facility staff do not agree with this choice. The Transition Coordinator must be able to work collaboratively with people who may not agree while maintaining the individual's right to choose and at the same time assuring their health and welfare. This can be very stressfull because of the many layers of responsibility to the individual, stakeholders and the grant requirements.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Performing key work tasks for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, identifying an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Perform accurate assessments that identify an individual's needs and develop care plans that will adequately meet their needs once they transition out of the nursing facility.
- Assuring successful transitions from the nursing facility to the community. Because people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare.
- Performing work tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Working with providers and/or families who may not agree with an individual's decision to leave the nursing facility.	estimate 30%
Must assure the continued health and welfare of potentially "at risk" individuals after leaving the nursing facility.	100%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients; fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
None	

c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
None		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
Sitting at a desk	estimate 30%
office/field work - meetings/ sitting, reaching, typing	estimate 80%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature **(required)**: _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Project Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this employee have excellent assessment skills to identify the health, clinical, social, financial and environmental needs of people in need of long-term care services. This employee must have the skills to identify the barriers keeping people from being able to leave nursing homes and the ability to create, review and monitor care plans for people in need of long-term care services. This employee must have existing knowledge of the systems that affect people who are aging and/or are living with a disability, including community-based long-term care. This position must also have the ability to develop trust and good working relationships with multiple stakeholders, families and people living in nursing homes.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 24.

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____	Date Received (Stamp) _____
Action Taken: _____	
New Job Title _____	
Current Class Code _____	New Class Code _____
Current Pay Grade _____	New Pay Grade _____
Current Mgt Level _____ B/U _____ OT Cat. _____ EEO Cat. _____ FLSA _____	
New Mgt Level _____ B/U _____ OT Cat. _____ EEO Cat. _____ FLSA _____	
Classification Analyst _____ Date _____	Effective Date: _____
Comments: _____	Date Processed: _____
Willis Rating/Components: _____	Knowledge & Skills: _____ Mental Demands: _____ Accountability: _____
	Working Conditions: _____ Total: _____

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Quality Management Specialist
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671-1601
Supervisor's Name, Title and Phone Number: Program Director - TBD

Type of Request:

- Management:** A management request to review the classification of an existing position, class, or create a new job class.
- Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new full-time position to a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

1. (What) Oversee 24/7 back-up system for the MFP grant.

(How) By working directly with provider agencies and the local 211 provider to assure people receiving services in the community are able to receive back-up support 24-hours a day, seven days per week. By educating case managers, provider agencies and MFP staff on the procedures for the 24/7 back-up system.

(Why) To help assure the health and welfare of people transitioning from nursing facilities to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

2. (What) Oversee critical incident reporting system for MFP.

(How) By working with the Program Director, DAIL staff and provider agencies to implement critical incident reporting system for people being serviced by the MFP grant. By taking the lead in receiving and processing critical incident reports according to MFP Operational Protocol. By coordinating critical incident data collection and work with the MFP Data Analyst on data reporting. By working with the Division of Licensing and Protection to coordinate MFP critical incident reporting with existing reporting requirements. By educating provider agencies regarding their critical incident reporting responsibilities.

(Why) To help assure the health and welfare of people transitioning from nursing facilities to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

3. (What) Oversee risk mitigation programs.

(How) By working with the Program Director, provider agencies and stakeholders to

identify existing risk mitigations programs, develop potential new risk mitigations programs and review the effectiveness of risk mitigation programs for people being served by MFP.

(Why) To help assure the continued health and welfare of people transitioning from nursing facilities to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

4. (What) Perform all required quality management and program utilization review activities.

(How) By working with the Program Director and other MFP staff to identify all MFP required quality management activities. By working with CMS technical assistance contractors to identify grant expectations and best practices regarding quality assurance and improvement. By reviewing program utilization and identify potential barriers to program usage through quality management activities. By consulting with provider agencies and MFP staff to identify strategies for quality improvement. By providing technical assistance and leadership to provider agencies and MFP staff in DAIL and CMS quality management philosophies and approaches. By educating MFP staff and provider agencies on existing rules regarding abuse, neglect and exploitation and Medicaid fraud, waste and abuse. By receiving and processing complaints regarding MFP grant.

(Why) To help assure the continued health and welfare of people transitioning from nursing facilities to the community. To assure full utilization of the MFP grant. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

5. (What) Assist with independent evaluation as necessary.

(How) By participating in program review activities as assigned by the Program Director, AHS, DAIL, and/or CMS.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

6. (What) Assist in writing/updating the MFP Operational Protocol as needed.

(How) By editing the Operational Protocol in Microsoft Word as requested by the Program Director. By submitting requested changes to the Program Director for review prior to submission to CMS for approval.

(Why) To maintain accurate documentation of program standards, policies and procedures according to CMS criteria.

7. (What) Assist in analyzing data related to the MFP grant.

(How) Work with the Program Director and Data Analyst to review data as it relates to program utilization, quality and set benchmarks. To use data to identify and implement program changes as needed and to provide feedback to providers.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

8. (What) Oversee certification and licensure reviews of clinical staff and housing.

(How) By participating as needed in state provider certification and licensure reviews. By verifying other applicable required certifications and licensures.

(Why) To help assure that services are provided according to state and federal rules and to assure the MFP grant is operating according to federal Terms & Conditions and approved Operational Protocol.

9. (What) Assist the Program Director and Data Analyst with MFP financial and performance reporting as needed.

(How) By participating in meetings as needed to review required reporting as it relates to program quality and utilization.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

10. (What) Provide ongoing monitoring of all MFP program activities.

(How) By working closely with the Program Director, other MFP in staff, and DAIL to develop and implement a means of monitoring MFP program activities.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

11. Perform other duties as assigned.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

This position will report directly to the MFP Program Director who reports to the Commissioner. This position will work with the Centers for Medicare and Medicaid Services, MFP technical assistance contractors as needed.

This position is responsible for coordinating and performing all quality management activities for the MFP grant. Therefore, this position must have personal contact and interaction with multiple provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, Adult Day providers, housing agencies, and transportation agencies.

This position will also have similar contact with State agencies such as the Department for Children and Families (DCF) regarding public benefits and Choices for Care eligibility, the Division of Licensing and Protection (DLP) for regulatory issues and matters of adult abuse, neglect and exploitation, the Department of VT Health Access regarding program integrity and the Attorney General's office regarding Medicaid Fraud. This position will also have direct contact with the Office of Public guardian when an individual has been appointed a public guardian and the local DAIL Long-Term Care clinical coordinator regarding clinical eligibility and coordination of services.

This position will have contact with DDAS Unit Directors and program staff to coordinate the overall quality management goals within DDAS.

This position will Collaborate with DDAS Choices for Care staff and Data Unit staff to develop program-wide critical incident reporting and complaint tracking.

This position will work on Departmental and Unit work groups to coordinate set MFP quality goals, objectives and processes.

This position will collaborate with AAA and HHA Case management supervisors and case managers to present MFP program quality measures, facilitate change, identify training, monitor practice, evaluate progress.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Knowledge and understanding of the theories and practices of quality management.
- Ability to negotiate and mediate areas of disagreement to build consensus within groups.
- Ability to work independently and set priorities among competing demands.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home- and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home- and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Ability to understand, interpret and apply state and federal regulations.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Ability to present information and policy to the public and solicit the public's opinions.
- Ability to prepare detailed analyses of problem situations and implement practical and attainable solutions.
- Ability to use Microsoft Word, Excel and Outlook and other database applications.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAIL Commissioner. This position will independently schedule work based on their assigned work plan. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Synthesizing national initiatives and best practices into workable program components to meet the needs of Vermont.

Creating and sustaining a willing and positive attitude for change with stakeholders that may be resistant to change and managing and initiating the change process in such a manner that creates enthusiasm and buy-in from the providers and stakeholders.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*

- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Performing key quality management tasks for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, coordinating all quality management functions for a grant that will help an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Identifying areas of quality improvement that will directly affect the health and welfare of people served by this grant. Because people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare.
- Performing work tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping assure quality care and services to an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Confrontation	10%
Mediation and consensus building	20%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
Poor driving conditions	15% frequent during winter months

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
n/a		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
office/field work - meetings/ sitting, reaching, typing	80%
driving	20%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature (**required**): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Program Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have existing knowledge about quality management systems that affect people who are aging and/or live with disabilities. The employee in this position must have the ability to work closely with multiple stakeholders and to foster good working relationships. It is important that this employee have the skills to evaluate the quality management systems needs for a new grant program within existing long-term care regulations. This employee must also be an active participant in the development and implementation of a new grant program with an existing long-term care system.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 24.

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

Organizational charts are **required** and must indicate where the position reports.

Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

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For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp) _____
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
New Mgt Level _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
Classification Analyst: _____	Date _____	Effective Date _____
Comments: _____		Date Processed: _____
Willis Rating/Components: _____	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Accountability: _____
	Total: _____	

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Quality Management Specialist
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671-1601
Supervisor's Name, Title and Phone Number: Program Director - TBD

Type of Request:

- Management:** A management request to review the classification of an existing position, class, or create a new job class.
- Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new full-time position to a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

1. (What) Oversee 24/7 back-up system for the MFP grant.

(How) By working directly with provider agencies and the local 211 provider to assure people receiving services in the community are able to receive back-up support 24-hours a day, seven days per week. By educating case managers, provider agencies and MFP staff on the procedures for the 24/7 back-up system.

(Why) To help assure the health and welfare of people transitioning from nursing facilities to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

2. (What) Oversee critical incident reporting system for MFP.

(How) By working with the Program Director, DAILE staff and provider agencies to implement critical incident reporting system for people being serviced by the MFP grant. By taking the lead in receiving and processing critical incident reports according to MFP Operational Protocol. By coordinating critical incident data collection and work with the MFP Data Analyst on data reporting. By working with the Division of Licensing and Protection to coordinate MFP critical incident reporting with existing reporting requirements. By educating provider agencies regarding their critical incident reporting responsibilities.

(Why) To help assure the health and welfare of people transitioning from nursing facilities to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

3. (What) Oversee risk mitigation programs.

(How) By working with the Program Director, provider agencies and stakeholders to

identify existing risk mitigations programs, develop potential new risk mitigations programs and review the effectiveness of risk mitigation programs for people being served by MFP.

(Why) To help assure the continued health and welfare of people transitioning from nursing facilities to the community. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

4. (What) Perform all required quality management and program utilization review activities.

(How) By working with the Program Director and other MFP staff to identify all MFP required quality management activities. By working with CMS technical assistance contractors to identify grant expectations and best practices regarding quality assurance and improvement. By reviewing program utilization and identify potential barriers to program usage through quality management activities. By consulting with provider agencies and MFP staff to identify strategies for quality improvement. By providing technical assistance and leadership to provider agencies and MFP staff in DAIL and CMS quality management philosophies and approaches. By educating MFP staff and provider agencies on existing rules regarding abuse, neglect and exploitation and Medicaid fraud, waste and abuse. By receiving and processing complaints regarding MFP grant.

(Why) To help assure the continued health and welfare of people transitioning from nursing facilities to the community. To assure full utilization of the MFP grant. To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

5. (What) Assist with independent evaluation as necessary.

(How) By participating in program review activities as assigned by the Program Director, AHS, DAIL, and/or CMS.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

6. (What) Assist in writing/updating the MFP Operational Protocol as needed.

(How) By editing the Operational Protocol in Microsoft Word as requested by the Program Director. By submitting requested changes to the Program Director for review prior to submission to CMS for approval.

(Why) To maintain accurate documentation of program standards, policies and procedures according to CMS criteria.

7. (What) Assist in analyzing data related to the MFP grant.

(How) Work with the Program Director and Data Analyst to review data as it relates to program utilization, quality and set benchmarks. To use data to identify and implement program changes as needed and to provide feedback to providers.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

8. (What) Oversee certification and licensure reviews of clinical staff and housing.

(How) By participating as needed in state provider certification and licensure reviews. By verifying other applicable required certifications and licensures.

(Why) To help assure that services are provided according to state and federal rules and to assure the MFP grant is operating according to federal Terms & Conditions and approved Operational Protocol.

9. (What) Assist the Program Director and Data Analyst with MFP financial and performance reporting as needed.

(How) By participating in meetings as needed to review required reporting as it relates to program quality and utilization.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

10. (What) Provide ongoing monitoring of all MFP program activities.

(How) By working closely with the Program Director, other MFP in staff, and DAIL to develop and implement a means of monitoring MFP program activities.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

11. Perform other duties as assigned.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

This position will report directly to the MFP Program Director who reports to the Commissioner. This position will work with the Centers for Medicare and Medicaid Services, MFP technical assistance contractors as needed.

This position is responsible for coordinating and performing all quality management activities for the MFP grant. Therefore, this position must have personal contact and interaction with multiple provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, Adult Day providers, housing agencies, and transportation agencies.

This position will also have similar contact with State agencies such as the Department for Children and Families (DCF) regarding public benefits and Choices for Care eligibility, the Division of Licensing and Protection (DLP) for regulatory issues and matters of adult abuse, neglect and exploitation, the Department of VT Health Access regarding program integrity and the Attorney General's office regarding Medicaid Fraud. This position will also have direct contact with the Office of Public guardian when an individual has been appointed a public guardian and the local DAIL Long-Term Care clinical coordinator regarding clinical eligibility and coordination of services.

This position will have contact with DDAS Unit Directors and program staff to coordinate the overall quality management goals within DDAS.

This position will Collaborate with DDAS Choices for Care staff and Data Unit staff to develop program-wide critical incident reporting and complaint tracking.

This position will work on Departmental and Unit work groups to coordinate set MFP quality goals, objectives and processes.

This position will collaborate with AAA and HHA Case management supervisors and case managers to present MFP program quality measures, facilitate change, identify training, monitor practice, evaluate progress.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Knowledge and understanding of the theories and practices of quality management.
- Ability to negotiate and mediate areas of disagreement to build consensus within groups.
- Ability to work independently and set priorities among competing demands.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home- and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home- and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Ability to understand, interpret and apply state and federal regulations.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Ability to present information and policy to the public and solicit the public's opinions.
- Ability to prepare detailed analyses of problem situations and implement practical and attainable solutions.
- Ability to use Microsoft Word, Excel and Outlook and other database applications.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAILE Commissioner. This position will independently schedule work based on their assigned work plan. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Synthesizing national initiatives and best practices into workable program components to meet the needs of Vermont.

Creating and sustaining a willing and positive attitude for change with stakeholders that may be resistant to change and managing and initiating the change process in such a manner that creates enthusiasm and buy-in from the providers and stakeholders.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*

- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Performing key quality management tasks for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, coordinating all quality management functions for a grant that will help an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Identifying areas of quality improvement that will directly affect the health and welfare of people served by this grant. Because people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare.
- Performing work tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping assure quality care and services to an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Confrontation	10%
Mediation and consensus building	20%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
Poor driving conditions	15% frequent during winter months

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
n/a		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
office/field work - meetings/ sitting, reaching, typing	80%
driving	20%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Program Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have existing knowledge about quality management systems that affect people who are aging and/or live with disabilities. The employee in this position must have the ability to work closely with multiple stakeholders and to foster good working relationships. It is important that this employee have the skills to evaluate the quality management systems needs for a new grant program within existing long-term care regulations. This employee must also be an active participant in the development and implementation of a new grant program with an existing long-term care system.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 24.

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature **(required)**: _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature **(required)**

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
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Request for Classification Review Position Description Form A

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Notice of Action # _____		Date Received (Stamp)
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Current Class Code _____	New Class Code _____	
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Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

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Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671-1601
Supervisor's Name, Title and Phone Number: Program Director - TBD

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(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

10. (What) Provide ongoing monitoring of all MFP program activities.

(How) By working closely with the Program Director, other MFP in staff, and DAIL to develop and implement a means of monitoring MFP program activities.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

11. Perform other duties as assigned.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

This position will report directly to the MFP Program Director who reports to the Commissioner. This position will work with the Centers for Medicare and Medicaid Services, MFP technical assistance contractors as needed.

This position is responsible for coordinating and performing all quality management activities for the MFP grant. Therefore, this position must have personal contact and interaction with multiple provider agencies such as nursing homes, Area Agencies on Aging, Home Health Agencies, Adult Day providers, housing agencies, and transportation agencies.

This position will also have similar contact with State agencies such as the Department for Children and Families (DCF) regarding public benefits and Choices for Care eligibility, the Division of Licensing and Protection (DLP) for regulatory issues and matters of adult abuse, neglect and exploitation, the Department of VT Health Access regarding program integrity and the Attorney General's office regarding Medicaid Fraud. This position will also have direct contact with the Office of Public guardian when an individual has been appointed a public guardian and the local DAIL Long-Term Care clinical coordinator regarding clinical eligibility and coordination of services.

This position will have contact with DDAS Unit Directors and program staff to coordinate the overall quality management goals within DDAS.

This position will Collaborate with DDAS Choices for Care staff and Data Unit staff to develop program-wide critical incident reporting and complaint tracking.

This position will work on Departmental and Unit work groups to coordinate set MFP quality goals, objectives and processes.

This position will collaborate with AAA and HHA Case management supervisors and case managers to present MFP program quality measures, facilitate change, identify training, monitor practice, evaluate progress.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Knowledge and understanding of the theories and practices of quality management.
- Ability to negotiate and mediate areas of disagreement to build consensus within groups.
- Ability to work independently and set priorities among competing demands.
- Considerable knowledge of principles and practices of disability issues and independent living as applied in home- and community-based service programs.
- Considerable knowledge of aging issues and long-term care services in home- and community-based settings.
- Considerable knowledge of state and federal rules and regulations relating to disability and elder issues and programs.
- Working knowledge of Medicaid services that provide supportive services to elders and people with disabilities.
- Familiarity with the disability and elder care provider and advocacy systems.
- Ability to understand, interpret and apply state and federal regulations.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people including families, providers, other human service and housing organizations.
- Ability to express ideas clearly and concisely in oral and written form.
- Ability to present information and policy to the public and solicit the public's opinions.
- Ability to prepare detailed analyses of problem situations and implement practical and attainable solutions.
- Ability to use Microsoft Word, Excel and Outlook and other database applications.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAIL Commissioner. This position will independently schedule work based on their assigned work plan. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Synthesizing national initiatives and best practices into workable program components to meet the needs of Vermont.

Creating and sustaining a willing and positive attitude for change with stakeholders that may be resistant to change and managing and initiating the change process in such a manner that creates enthusiasm and buy-in from the providers and stakeholders.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*

- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Performing key quality management tasks for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, coordinating all quality management functions for a grant that will help an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Identifying areas of quality improvement that will directly affect the health and welfare of people served by this grant. Because people being helped by this grant are vulnerable and frail, there is a high level of accountability for their health and welfare.
- Performing work tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping assure quality care and services to an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Confrontation	10%
Mediation and consensus building	20%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
Poor driving conditions	15% frequent during winter months

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
n/a		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
office/field work - meetings/ sitting, reaching, typing	80%
driving	20%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Program Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this position have existing knowledge about quality management systems that affect people who are aging and/or live with disabilities. The employee in this position must have the ability to work closely with multiple stakeholders and to foster good working relationships. It is important that this employee have the skills to evaluate the quality management systems needs for a new grant program within existing long-term care regulations. This employee must also be an active participant in the development and implementation of a new grant program with an existing long-term care system.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay grade 24.

Supervisor's Signature (required): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

VERMONT DEPARTMENT OF PERSONNEL
Request for Classification Review
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

INSTRUCTIONS: Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

To Submit this Request for Classification Review: If this is a filled position, the employee must sign the original* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.

Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____		Date Received (Stamp)
Action Taken: _____		
New Job Title _____		
Current Class Code _____	New Class Code _____	
Current Pay Grade _____	New Pay Grade _____	
Current Mgt Level: _____ B/U _____	OT Cat. _____	EEO Cat. _____ FLSA _____
New Mgt Level _____	B/U _____	OT Cat. _____ EEO Cat. _____ FLSA _____
Classification Analyst _____	Date _____	Effective Date: _____
Comments: _____		Date Processed: _____
Willis Rating/Components:	Knowledge & Skills: _____	Mental Demands: _____
	Working Conditions: _____	Total: _____
		Accountability: _____

Incumbent Information:

Employee Name: Employee Number:
Position Number: Current Job/Class Title:
Agency/Department/Unit: Work Station: Zip Code:
Supervisor's Name, Title, and Phone Number:
How should the notification to the employee be sent: employee's work location or other address, please provide mailing address:

New Position/Vacant Position Information:

New Position Authorization: "Money Follows the Person" grant, Dept of Health & Human Services - Award #1LICMS330824-01-00, Fed Cat No. #93.791 Request Job/Class Title: Aging and Disabilities Senior Planner
Position Type: Permanent or Limited / Funding Source: Core, Partnership, or Sponsored
Vacant Position Number: N/A Current Job/Class Title: N/A
Agency/Department/Unit: AHS/DAIL/DDAS Work Station: Waterbury Zip Code: 05671-1601
Supervisor's Name, Title and Phone Number: Program Director - TBD

Type of Request:

Management: A management request to review the classification of an existing position, class, or create a new job class.

Employee: An employee's request to review the classification of his/her current position.

1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Intro:

This request is for a new full-time position to a new \$23 million dollar federal US Dept of Health & Human Services (HHS), Affordable Care Act grant called "Money Follows the Person" (MFP). Federal oversight of this grant is managed by the HHS Centers for Medicare & Medicaid Services (CMS). This position is 100% federally funded through March 31, 2016.

1. (What) Designs and implements management information systems related to long-term care services and the MFP grant.

(How) By consulting with MFP and long-term care providers, MFP staff and DAIL staff to assess data collection needs and methods. By developing methods to generate statistics and reports necessary for the administration of publicly funded long term care services and MFP grant. By defining and recommending necessary improvements to management information systems.

(Why) To help assure that publicly funded long-term care services and the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

2. (What) Assist the Program Director in managing all required internal, state and federal reporting, tracking and data management, including management of MFP benchmarks and data integrity.

(How) By participating in strategic planning efforts and policy development. By working with the Program Director and DAIL staff to identify required reporting elements. By working with AHS and DAIL business office as needed to coordinate required reporting. By working with CMS technical assistance contractors to make sure reports are managed according to MFP grant. By working with a variety of internal and external stateholders to understand data needs, coordinate with division/unit capabilities and establish data collection tools/reports as well as system to collect data to support MFP program, operational and oversight activities.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

3. (What) Perform data analysis.

(How) By interpreting/translating program reporting needs into data elements.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

4. (What) Complete required MFP reports as needed.

(How) By working with Program Director and DAIL staff to identify required MFP reporting needs and methods. By working with identified databases and running specified reports on a regular basis as determined by the MFP grant.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

5. (What) Assist MFP Quality Management Specialists to manage program tracking systems.

(How) By working directly with DAIL staff and Quality Management Specialists to identify methods of tracking and reporting critical incidents, complaints and other required quality measures.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

6. (What) To assist in developing and updating the MFP portion of DAILs' website.

(How) By participating in strategic planning meetings with the Program Director and DAIL staff to identify MFP website needs and identifying staff responsible for placing information on the website. By participating in identifying MFP information and reports appropriate for the DAIL website, in accordance to CMS required language.

(Why) To help assure that the MFP grant is operating according to federal Term & Conditions and approved Operational Protocol. To help assure that the program goals are met and grant funding is continued.

7. Perform other duties as assigned.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

This position will report directly to the MFP Program Director who reports to the Commissioner. This position will work with the Centers for Medicare and Medicaid Services, MFP technical assistance contractors as needed.

This position is responsible for coordinating and performing all data analysis activities for the MFP grant. Therefore, this position must have personal contact and interaction with the

DAIL business office, AHS business office, DAIL Data Unit, DAIL Adult Services Unit and Commissioner's office.

This position will collaborate with external long-term care providers such as Area Agencies on Aging, Home Health Agencies and Nursing Facilities.

This position will also have similar contact with State agencies for the purpose of coordinating data, such as the Department for Children and Families (DCF), the Division of Licensing and Protection (DLP) and the Department of VT Health Access.

This position will have contact with DDAS Unit Directors and program staff to coordinate within the overall data analysis goals within DDAS.

This position will collaborate with DDAS Choices for Care staff and Data Unit staff to develop program-wide critical incident reporting and complaint tracking.

This position will participate on work groups to coordinate set MFP data analysis goals, objectives and processes.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

- Considerable knowledge of management information systems.
- Considerable knowledge of the principles and practices of program planning.
- Ability to conceptualize methods for the development of automated systems to manage and integrate large amounts of data.
- Ability to analyze complex problems and to develop and implement effective solutions.
- Ability to prepare detailed technical reports.
- Knowledge and understanding of the theories and practices of data analysis.
- Considerable knowledge of databases, data collection and creating data reports.
- Ability to work independently and set priorities among competing demands.
- Ability to understand, interpret and apply state and federal regulations.
- Ability to establish and maintain effective working relationships including the ability to interact respectfully and professionally with a wide variety of people.
- Ability to express ideas and present information clearly and concisely in oral and written form.
- Ability to prepare detailed analyses of problem situations and implement practical and attainable solutions.
- Ability to use Microsoft Word, Excel and Outlook and other database applications.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

This position will report directly to the MFP grant Program Director who will report directly to the DAIL Commissioner. This position will independently schedule work based on their assigned work plan. The Program Director will assign additional work as needed and provide regular one-on-one supervisory meetings. Because this grant is under development and the Program Director has not yet been hired, the method and style of supervision has yet to be fully developed.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Synthesizing national initiatives and best practices into workable program components to meet the needs of Vermont and MFP grant.

Providing management system and data support within federally regulated long-term care program and grant guidelines set forth by federal Terms and Conditions with an approved Operational Protocol.

Pressure to provide accurate data analysis and support to a highly funded new program that will have a lot of attention at the state and federal level.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

This position is accountable for:

- Developing management information systems and performing data analysis and support for a new \$23 million dollar federal grant in accordance with federally approved Terms & Conditions and Operational Protocol.
- Over the next five years, coordinating all management information system and data analysis functions for a grant that will help an estimated 375 people who have been in a nursing facility for more than 90 days and wish to leave, but are unable to leave because of a barrier to care, supports and/or housing alternatives in the community.
- Performing data analysis and reporting tasks that will help assure compliance with required federal CMS Terms & Conditions and approved Operational Protocol.
- Helping assure accurate data analysis and reporting for services to an estimated 375 people over the next five years to transition from nursing homes to a community based living arrangement. This is consistent with the goal of the Department to provide choices to people so they can direct their own lives by receiving long-term care in community-based settings if they so choose.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?
Repetitive computer work	estimated 85 %
Scrutiny of accuracy of data	30%
Complying with federal reporting timelines that could affect continued grant funding.	30%

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
Repetitive computer work	estimated 85%

c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?
n/a		

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?
desk work, repetitive computer work	85%

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

Employee's Signature (required): _____ Date: _____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

NOTE: This position will be supervised by the Program Director who has yet to be hired.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

It is most important that this employee be independent in their ability to develop and implement management information, data analysis and reporting systems for the new MFP grant. This employee must have exceptional analytical skills and be confident in their ability to assess the needs of the long-term care systems and MFP grant.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Pay Grade 24

Supervisor's Signature (**required**): _____ Date: _____

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

Personnel Administrator's Signature (**required**): _____ Date: _____

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Appointing Authority or Authorized Representative Signature (**required**)

Date

APPENDIX K

Money Follows the Person Demonstration Worksheet for Proposed Budget (revised March 31, 2011)

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will autopopulate. Please **DO NOT** alter any formulas.
Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates.

Date of Report: 3/29/2011		Please express FMAP as a decimal. (example: 68.32%=.6832)				
Name of State/Grantee: Department of Vermont Health Access (DVHA)		State FMAP (fiscal Harmonized Rate Oct 2008 - Dec 2010)	State Enhanced FMAP	Increased FMAP (Oct 2008 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP
Grant #:		FFY 2007	0.50000		0.50000	
CMS-1L1-11-001		FFY 2008	0.50000		0.50000	
Demonstration Program Title: Money Follows the Person Rebalancing Grant Demonstration	10-12/2008	FFY 2009 Q1	0.50000		0.50000	0.50000
	1-3/2009	FFY 2009 Q2	0.50000		0.50000	0.50000
	4-6/2009	FFY 2009 Q3	0.50000		0.50000	0.50000
	7-9/2009	FFY 2009 Q4	0.50000		0.50000	0.50000
	10-12/2009	FFY 2010 Q1	0.50000		0.50000	0.50000
	1-3/2010	FFY 2010 Q2	0.50000		0.50000	0.50000
	4-6/2010	FFY 2010 Q3	0.50000		0.50000	0.50000
	7-9/2010	FFY 2010 Q4	0.50000		0.50000	0.50000
	10-12/2010	FFY 2011 Q1	0.50000		0.50000	0.50000
	1-3/2011	FFY 2011 Q2	0.50000		0.50000	0.50000
	4-6/2011	FFY 2011 Q3	0.5871	0.79355	0.65240	0.82620
	7-12/2011	FFY 2011 Q4	0.5871	0.79355		0.79355
		FFY 2012	0.5758	0.78790		0.78790
		FFY 2013	0.5758	0.78790		0.78790
		FFY 2014	0.5758	0.78790		0.78790
		FFY 2015	0.5758	0.78790		0.78790
		FFY 2016	0.5758	0.78790		0.78790

APPENDIX K

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.
All population counts and budget estimates are based on the *Calendar Year (CY)*.

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total per CY
CY 2007						0
CY 2008						0
CY 2009						0
CY 2010						0
CY 2011	23		2			25
CY 2012	60		10			70
CY 2013	65		10			75
CY 2014	73		12			85
CY 2015	77		13			90
CY 2016	26		4			30
Total Count	324	0	51	0	0	
				Total of Populations	375	

Demonstration Budget Summary

Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services are defined in the RFP.

Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7); *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); *Administrative - Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).

Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	Rate	Total Costs	Federal	State
Qualified HCBS		\$ 16,324,312	\$ 12,864,542	\$ 3,459,771
Demonstration HCBS		\$ 906,250	\$ 714,211	\$ 192,039
Supplemental		\$ -	\$ -	\$ -
Administrative - Normal		\$ -	\$ -	\$ -
Administrative - 75%		\$ -	\$ -	\$ -
Administrative - 90%		\$ -	\$ -	\$ -
Federal Evaluation Supports		\$ 37,500	\$ 37,500	\$ -
Administrative (Other) - 100%		\$ 3,838,371	\$ 3,838,371	\$ -
State Evaluation		\$ -	\$ -	\$ -
Total		\$ 21,106,433	\$ 17,454,624	\$ 3,651,810

Per Capita Service Costs	\$ 45,948
Per Capita Admin Costs	\$ 10,236

Rebalancing Fund Calculation	
CY 2007	\$ -
CY 2008	\$ -
CY 2009	\$ -
CY 2010	\$ -
CY 2011	\$ 102,040
CY 2012	\$ 627,101
CY 2013	\$ 717,920
CY 2014	\$ 869,596
CY 2015	\$ 984,315
CY 2016	\$ 350,836
Rebalancing Fund Total	\$ 3,651,810

APPENDIX K

CY 2007	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.50000	\$ -	\$ -	\$ -	Grant Funding for CY 2007	\$ -
Demonstration HCBS	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Supplemental	0.00000	\$ -	\$ -	\$ -	Balance (Carry Over)	
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

CY 2008 (including Partial Year Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan - Sept)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Demonstration HCBS (Jan - Sept)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Supplemental (Jan - Sept)	0.00000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

APPENDIX K

CY 2009 (using Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Qualified HCBS (Jul- Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Demonstration HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Jul Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Jul- Sep increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

APPENDIX K

CY 2010 (using increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Qualified HCBS (Jul-Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Qualified HCBS (Oct-Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 988,475
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 988,475
Demonstration HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Jul-Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Oct-Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Jul-Sep increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Oct-Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

APPENDIX K

CY 2011 (using partial year increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ 988,475
Qualified HCBS (Apr-Jun increased FMAP)	0.82620	\$ -	\$ -	\$ -	Total Fed Costs	\$ 988,475
Qualified HCBS (Jul-Dec)	0.79355	\$ 463,013	\$ 367,424	\$ 95,589	Balance (Carry Over)	\$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 3,047,838
Demonstration HCBS (Apr-Jun increased FMAP)	0.82620	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 3,047,838
Demonstration HCBS (Jul-Dec)	0.79355	\$ 31,250	\$ 24,798	\$ 6,452		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.65240	\$ -	\$ -	\$ -		
Supplemental (Jul-Dec)	0.58710	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 5,000	\$ 5,000	\$ -		
Administrative (Other) - 100%	1.00000	\$ 591,253	\$ 591,253	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,090,516	\$ 988,475	\$ 102,040		

CY 2012	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.78790	\$ 2,781,631	\$ 2,191,647	\$ 589,984	Remaining Award Funding	\$ 3,047,838
Demonstration HCBS	0.78790	\$ 175,000	\$ 137,883	\$ 37,118	Total Fed Costs	\$ 3,047,838
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	\$ 3,407,438
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 3,407,438
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 5,500	\$ 5,500	\$ -		
Administrative (Other) - 100%	1.00000	\$ 712,808	\$ 712,808	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 3,674,939	\$ 3,047,838	\$ 627,101		

APPENDIX K

CY 2013	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.78790	\$ 3,197,319	\$ 2,519,168	\$ 678,151	Remaining Award Funding	\$ 3,407,438
Demonstration HCBS	0.78790	\$ 187,500	\$ 147,731	\$ 39,769	Total Fed Costs	\$ 3,407,438
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	\$ 3,991,742
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 3,991,742
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 6,000	\$ 6,000	\$ -		
Administrative (Other) - 100%	1.00000	\$ 734,539	\$ 734,539	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 4,125,358	\$ 3,407,438	\$ 717,920		

CY 2014	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.78790	\$ 3,887,436	\$ 3,062,911	\$ 824,525	Remaining Award Funding	\$ 3,991,742
Demonstration HCBS	0.78790	\$ 212,500	\$ 167,429	\$ 45,071	Total Fed Costs	\$ 3,991,742
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	\$ 4,440,063
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 4,440,063
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 6,500	\$ 6,500	\$ -		
Administrative (Other) - 100%	1.00000	\$ 754,903	\$ 754,903	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 4,861,339	\$ 3,991,742	\$ 869,596		

APPENDIX K

CY 2015	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78790	\$ 4,415,806	\$ 3,479,213	\$ 936,592	Remaining Award Funding \$ 4,440,063
Demonstration HCBS	0.78790	\$ 225,000	\$ 177,278	\$ 47,723	Total Fed Costs \$ 4,440,063
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year \$ 1,579,068
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 1,579,068
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ 7,000	\$ 7,000	\$ -	
Administrative (Other) - 100%	1.00000	\$ 776,572	\$ 776,572	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 5,424,378	\$ 4,440,063	\$ 984,315	

CY 2016	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78790	\$ 1,579,108	\$ 1,244,179	\$ 334,929	Remaining Award Funding \$ 1,579,068
Demonstration HCBS	0.78790	\$ 75,000	\$ 59,093	\$ 15,908	Total Fed Costs \$ 1,579,068
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ -
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ 7,500	\$ 7,500	\$ -	
Administrative (Other) - 100%	1.00000	\$ 268,296	\$ 268,296	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 1,929,904	\$ 1,579,068	\$ 350,836	

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Notice of Award (NOA)

SAI NUMBER:

PMS DOCUMENT NUMBER:
1LI330824A

1. AWARDING OFFICE: Centers For Medicare & Medicaid Services		2. ASSISTANCE TYPE: Discretionary Grant		3. AWARD NO.: 1LICMS330824-01-00		4. AMEND. NO. 0		
5. TYPE OF AWARD: Demonstration			6. TYPE OF ACTION: New			7. AWARD AUTHORITY: Patient Protection and Affordable Care Act		
8. BUDGET PERIOD: 04/01/2011 THRU 03/31/2012			9. PROJECT PERIOD: 04/01/2011 THRU 03/31/2016			10. CAT NO.: 93.791		
11. RECIPIENT ORGANIZATION: VT Department of Disabilities, Aging and Independent Living Disability and Aging Services 103 S Main St Waterbury, VT 05671-9800 Camille George						12. PROJECT / PROGRAM TITLE: Vermont Money Follows the Person Project		

13. COUNTY: Washington		14. CONGR. DIST.: 00		15. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR: Camille George			
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16. APPROVED BUDGET:				17. AWARD COMPUTATION:					
Personnel.....	\$	0		A. NON-FEDERAL SHARE.....	\$	0	0%		
Fringe Benefits.....	\$	0		B. FEDERAL SHARE.....	\$	2,123,975	100%		
Travel.....	\$	0		18. FEDERAL SHARE COMPUTATION:					
Equipment.....	\$	0		A. TOTAL FEDERAL SHARE.....	\$	2,123,975			
Supplies.....	\$	0		B. UNOBLIGATED BALANCE FEDERAL SHARE.....	\$	0			
Contractual.....	\$	0		C. FED. SHARE AWARDED THIS BUDGET PERIOD...\$		0			
Facilities/Construction.....	\$	0		19. AMOUNT AWARDED THIS ACTION:					
Other.....	\$	2,123,975			\$	2,123,975			
Direct Costs.....	\$	2,123,975		20. FEDERAL \$ AWARDED THIS PROJECT PERIOD:					
Indirect Costs.....	\$	0			\$	2,123,975			
At % of \$				21. AUTHORIZED TREATMENT OF PROGRAM INCOME: ADDITIONAL COSTS					
Total Approved Budget.....				22. APPLICANT EIN:		23. PAYEE EIN:		24. OBJECT CLASS:	
\$ 2,123,975				1036000264A1		1036000264A1		41.45	

25. FINANCIAL INFORMATION:

DUNS: 809376155

ORGN	DOCUMENT NO.	APPROPRIATION	CAN NO.	NEW AMT.	UNOBLIG.	NONFED %
CMS	1LI330824A	75960516	1-5992140	\$2,123,975		

26. REMARKS: (Continued on separate sheets)

See next page

27. SIGNATURE - GRANTS OFFICER <i>Mary Greene</i> Mary Greene		DATE: MAR 02 2011		28. SIGNATURE(S) CERTIFYING FUND AVAILABILITY Signature Not Required	
29. SIGNATURE AND TITLE - PROGRAM OFFICIAL(S) Jeffrey Clopein Signature Not Required				DATE:	

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Notice of Award (NOA)

SAI NUMBER:

PMS DOCUMENT NUMBER:
1LI330824A

1. AWARDING OFFICE: Centers For Medicare & Medicaid Services	2. ASSISTANCE TYPE: Discretionary Grant	3. AWARD NO.: 1LICMS330824-01-00	4. AMEND. NO. 0
5. TYPE OF AWARD: Demonstration	6. TYPE OF ACTION: New	7. AWARD AUTHORITY: Patient Protection and Affordable Care .	
8. BUDGET PERIOD: 04/01/2011 THRU 03/31/2012	9. PROJECT PERIOD: 04/01/2011 THRU 03/31/2016	10. CAT NO.: 93.791	
11. RECIPIENT ORGANIZATION: VT Department of Disabilities, Aging and Independent Living			

26. REMARKS (Continued from previous page)

The purpose of this Notice of Award (NoA) is to authorize funding in the amount of \$2,123,975 for the budget period of April 1, 2011 through March 31, 2012. Attached are the terms and conditions applicable for this grant award.

This award may be subject to the Transparency Act sub-award and executive compensation reporting requirements of 2 CFR Part 170.

Within 30 days from the date of this award, the grantee agrees to provide to the CMS Grants Management Officer and CMS Project Officer a revised budget equal to the amount of the award on Standard Form 424A, Section B only and; the approved Indirect Cost Rate Agreement used in calculating the budget, if applicable.

For administrative assistance, please contact your Grants Management Specialist: Linda Gmeiner at 410-786-9954 or linda.gmeiner@cms.hhs.gov.

For programmatic assistance, please contact your Project Officer: Jeffrey Clopein at 410-786-7252 or Jeffrey.clopein@cms.hhs.gov.

Please remember to include your grant number on all correspondence. The award number is located in Section 3 of the NoA.

For CMS Purposes Only: Transmittal # 75212140-02 / BOAX # 121402

1911

Vermont

Money Follows the Person Rebalancing Demonstration

State Specific Terms and Conditions

Organization and Administration

1. (Page 27 of 270) Please clarify the needs that are not being met for complex longer-stay residents. Three additional needs were identified - one-time financial assistance to relocate to the community, service settings that include 24-hour supervision, and supports for BH needs. Why would these be specific to longer-stay nursing home residents? How does the State define "longer stay"? Will the services to address these gaps be available to all Choices for Care beneficiaries?
2. (Page 28 of 270) Please define DAIL early in the document the term appears several times in the narrative prior to its definition on page 36 of 270.
3. (Page 30 of 270) Please explain why the transition coordinator would be solely responsible for the development of the plan of care, in collaboration with the participant and case manager. Please explain how the assessment and care planning process addresses the full range of the participant's needs and preferences. Please also describe the qualifications and training of the transition coordinator to perform all of these varied duties, from identifying potential MFP participants to discharge planning.
4. (Page 31-32 of 270) The State has identified a strong reliance upon the addition of the new Adult Family Care service to Choices for Care to address two of the three gaps identified (24 hour supervision and supports for individuals with BH needs). Where is this new service? Please provide an assurance that sufficient numbers of these providers are/will be available both to transition MFP participants, and to meet the needs of non-MFP Choices for Care beneficiaries.
5. (Page 28 of 270) Please submit job descriptions when they are final.
6. (Page 36 of 270) Proposal describes intent to contract with non-service providers to serve as transition consultants. Please explain their role.

Benchmarks

7. (Page 42 of 270) Benchmark 5 appears to be a measure of success of the MFP demonstration and perhaps belongs as part of the evaluation. It does not appear to be a benchmark as described in our guidance. Please explain how this benchmark measures the progress made by the State in directing savings from the enhanced FMAP towards rebalancing.
8. (Page 40-42 of 270) Benchmarks 3 & 4 are not related to rebalancing. #3 is a function of Benchmark #1. Please revise benchmarks to address rebalancing and please explain how the rebalancing funds will be used.
9. (Page 15 of 270) Benchmark 2: Qualified HCBS Expenditures. It is recommended that the state expand the narrative for this benchmark to clarify which categories of HCBS spending are and are not included in the projected annual HCBS qualified expenditures targets. In addition, it would be helpful to better understand what factors led Vermont to base the future expenditure projections on a trend rate of two percent.
10. (Page 16-18 of 270) Benchmark 3-5 (Additional Benchmarks). Overall, Vermont's additional benchmarks support efforts to transition (and keep) more individuals to the

community; however, it is recommended that the state include additional narrative to specify how these benchmarks will reinvest the state's funds from the enhanced FMAP to permanently affect the LTC system towards increased HCBS.

11. (Page 17 of 270) Benchmark 4 (Additional Benchmark - Inform MFP-Eligible Residents about the Program). If Vermont implements a MFP program, the state will be reporting progress on this benchmark into the web-based reporting system. It would be helpful to know if Vermont plans to report progress made under this benchmark in numbers or percents.
12. (Page 18 of 270) Benchmark 5 (Additional Benchmark - Increase Number of MFP Participants who Remain in the Community after One Year). Similar to the comment re: Benchmark 3, it would be helpful to know if Vermont plans to report progress made under this benchmark in numbers or percents.
13. In addition, it is recommended that Vermont expand the narrative to further explain who the state considers in the count of 'total transitioning residents' (the denominator). In other words, if the state plans to report 80 percent progress to this benchmark in CY 2011, will that be 80 percent of WHAT? Will it include all individuals that have transitioned during 2011, all individuals who have reached their one year mark during 2011, or something else?
14. The grantee should revise its targets to start reporting progress in 2012 since that is the expected year that individuals will start reaching their one year mark and then determining whether or not they will remain in the community.

Participant Recruitment and Enrollment

15. (Page 48-49 of 270) Please confirm that a determination of receipt of Medicaid services can be verified through Vermont's Medicaid Eligibility system. Please also describe any secondary verification process, if any, that may be used as a backup to account for claims lag.
16. (Page 50 of 270) Please describe the State's policy for re-enrollment in the demonstration for a participant who is readmitted to a facility prior to completion of 12 months of demonstration services, and who is readmitted for a period of time greater than 30 days. (There is some mention in the informed consent form in Appendix D of multiple 30-day occurrences and potential disenrollment.)
17. (Page 67 of 270) Please explain the statement that the guardian must "visit the facility in which the ward is to be placed if it is proposed that the ward be placed outside his or her home". Is the term "facility" inclusive of non-institutional settings such as assisted living or adult foster care?
18. (Page 43 of 270) Please clarify whether transition coordinators will be DAIL employees and when a job description will be completed.
19. (Page 44 of 270) Please add that participants must be Medicaid recipients for at least one day prior to transition, although it's stated elsewhere.
20. (Page 45 of 270) Please describe the purpose of the consultation with the facility discharge planner and whether/how it leads to contact with the resident.
21. (Page 47- 49) Please clarify that the purpose of the qualified residence form is to explain the available residences. Is the transition assessment based on the ILA? If not, has it been developed or when will it be developed.

Informed Consent and Guardianship

22. (Page 60+ of 270) (general) Please identify the State agency/unit responsible for receiving and reviewing critical incident reports, responding to problems concerning critical events, and investigation consumer complaints regarding violations of their rights.

Outreach/Marketing/Education

23. (Page 63, 68 of 270) Please advise into which other languages, if any, the educational and outreach materials will be translated.
24. (Page 67 of 270) Please provide a staff training schedule, including provisions for new staff that enter the MFP program post-implementation (after the initial 4-6 week training period has ended). Please also include an estimated timeline for development of educational/marketing materials.
25. (Page 60 of 270) Please clarify who will be responsible for developing the materials.
26. (Page 61 of 270) Please explain the time line for developing the materials.
27. (Page 62 of 270) Please explain the vehicle for covering the topics listed. Training?
28. (Page 63-65 of 270) Please describe will be responsible for implementing the mass media and other activities and describe the time line.
29. (Page 74 of 270) Please describe how are consumers supported to attend meetings? Are materials sent in advance? Are support services available?

Stakeholder Involvement

30. (Pages 45-53 of 270) Please provide details on the efforts the State plans to make to engage select MFP participants in the MFP Advisory Board and ad hoc committee. For instance, will travel reimbursement or meal vouchers be available, or other incentives used?
31. (Page 74 of 270) Describe how consumer participation will be supported so they may attend meetings; provide input such as receiving materials in advance of meetings, and availability of supports if needed, stipends.

Benefits and Services

32. (Page 78 of 270) Please provide additional detail on the Choices for Care option, which is described as a managed care waiver using a fee-for-service delivery system. Is this a PCCM model?
33. (Page 80 of 270) Clarify whether there are waiting lists for high need applicants and if so how they will be addressed.

Consumer Supports

34. (Page 87 of 270) Please provide additional information on the anticipated or desired frequency of reporting to the QM specialist the number and type of participant calls for critical backup.
35. General: Please describe the transition coordinators' qualifications and expected ratio of coordinator to MFP participant.
36. (Pages 86-87 of 270) Please describe who will train the VT 211 staff and when it will be completed.

Self-Direction

37. (Page 95 of 270) Please discuss the qualifications of the case manager and consultant with respect to making a determination of the participant's cognitive ability and ability to communicate effectively.

Quality

38. (Page 111 of 270) The back- up proposal indicates that the participant handbook will include information about whom to call for 24 hour back up services. Please list the organizations, other than VT 211 that will be included in the list. Please describe how the state will monitor timely response to emergency back- up calls; track and document the number and type of calls and use the information in the QMS.

Housing

39. (Page 126 of 270) Please clarify whether the transition coordinator or another DAIL employee approves the documentation of the qualified residence.
40. (Page 129) Please describe any existing relationships between DAIL and housing agencies and whether any housing agencies have waiting lists and do they include preferences for people with disabilities

Continuity of Care

41. (Page 32 of 270) The narrative states that high needs individuals are served by the Choices for Care waiver "to the extent funding is available". Please explain what happens to these individuals if funding is not available.

Budget and Budget Narrative

42. (Page 15 of 270) per capita admin costs are greater than 440% of per capita service costs? Please explain why expenditures for qualified HCBS are so low.
43. (Page 110 of 270) Please indicate which DAIL unit manages Choices for Care and how coordination between CFC and MFP will occur.
44. (Page 138 of 270) Please explain whether the community development specialists will be independent contractors or organizations and how they will be selected.
45. (Page 141 of 270) When will the billing code for demonstration services be established?
46. (Page 145/152 of 270) The estimate for qualified HCBS expenditures should be verified for data entry errors. It seems unlikely that the per capita service cost could be so low, only \$711 per participant, and less than 1/3 of expenditures for demonstration services.
47. VT has outstanding documents that need to be corrected and resubmitted prior to grant approval (Federal Funds Only Worksheet and 424a form). They will also need to address the inconsistencies in their Per Capita calculations. The Per Capita Administrative claims requested is not supported by the service costs and the number of persons they intend to serve.
48. Grantee will be required to submit a revised staffing plan, budget narrative, SF-424a form (Sections b and c), and Worksheet for Proposed Budget form that reflects the 1st year spending at \$2,123,975, and total amount from 2011-2016 of 17,936,059. Administrative budget may NOT exceed \$3,592,612 or 20% on total program budget.

Attachment A

Award Term for Federal Financial Accountability and Transparency Act (FFATA) Subaward and Executive Compensation Reporting Requirement

I. Reporting Subawards and Executive Compensation.

a. Reporting of first-tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates \$25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to <http://www.fsrs.gov>.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action that the submission instructions posted at <http://www.fsrs.gov> specify.

b. Reporting Total Compensation of Recipient Executives.

1. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if—

i. the total Federal funding authorized to date under this award is \$25,000 or more;

ii. in the preceding fiscal year, you received—

(A) 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

(B) \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/excomp.htm>.)

2. Where and when to report. You must report executive total compensation described in paragraph b.1. of this award term:

i. As part of your registration profile at <http://www.ccr.gov>.

ii. By the end of the month following the month in which this award is made, and annually thereafter.

c. Reporting of Total Compensation of Subrecipient Executives.

1. Applicability and what to report. Unless you are exempt as provided in paragraph d. of this award term, for each first-tier subrecipient under this award, you shall report the names and total compensation of each of the subrecipient's five most highly compensated executives for the subrecipient's preceding completed fiscal year, if—

i. in the subrecipient's preceding fiscal year, the subrecipient received—

(A) 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

(B) \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/excomp.htm>.)

2. Where and when to report. You must report subrecipient executive total compensation described in paragraph c.1. of this award term:

i. To the recipient.

ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.

d. Exemptions

If, in the previous tax year, you had gross income, from all sources, under \$300,000, you are exempt from the requirements to report:

i. Subawards, and

ii. The total compensation of the five most highly compensated executives of any subrecipient.

e. Definitions. For purposes of this award term:

1. Entity means all of the following, as defined in 2 CFR part 25:

i. A Governmental organization, which is a State, local government, or Indian tribe;

ii. A foreign public entity;

iii. A domestic or foreign nonprofit organization;

iv. A domestic or foreign for-profit organization;

v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.

2. Executive means officers, managing partners, or any other employees in management positions.

3. Subaward:

i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.

ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see Sec. __ .210 of the attachment to OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations").

iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.

4. Subrecipient means an entity that:

i. Receives a subaward from you (the recipient) under this award; and

ii. Is accountable to you for the use of the Federal funds provided by the subaward.

5. Total compensation means the cash and noncash dollar value earned by the executive during the recipient's or subrecipient's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

i. Salary and bonus.

ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax-qualified.

vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000.

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
Organization and Administration			
1	(Page 27 of 270) Please clarify the needs that are not being met for complex longer-stay residents. Three additional needs were identified - one-time financial assistance to relocate to the community, service settings that include 24-hour supervision, and supports for BH needs. Why would these be specific to longer-stay nursing home residents? How does the State define "longer stay"? Will the services to address these gaps be available to all Choices for Care beneficiaries?	People who have been in a facility for more than 90 consecutive days, excluding a rehab stay, are more likely to be there because of a barrier to living in the community. Therefore, the stay is more likely to become a "permanent" stay. They are more likely to have lost their previous living arrangement in the community and are more likely to have a behavioral health or complex care need that poses a challenge to finding appropriate housing and care to support them back in the community. The state defines "longer stay" as 90 consecutive days or more, including at least one day on Vermont Medicaid and excluding Medicare short stay rehab days. The Transitional Funds will be only available to MFP participants. The "Adult Family Care" (24-hr community-based care) option will be developed as an option available to all Choices for Care participants. Added 90-day requirement to " <u>Criteria Used to Identify MFP Candidates</u> ".	Revision to OP: Section B.1, pg 22 of tracked changes document.
2	(Page 28 of 270) Please define DAIL early in the document the term appears several times in the narrative prior to its definition on page 36 of 270.	Updated the Operational Protocol to define DAIL on the first page it appears.	Revision to OP: Section A.1, pg 4 of tracked changes document.
3	(Page 30 of 270) Please explain why the transition coordinator would be solely responsible for the development of the plan of care, in collaboration with the participant and case manager. Please explain how the assessment and care planning process addresses the full range of the participant's needs and preferences. Please also describe the qualifications and training of the transition coordinator to perform all of these varied duties, from identifying potential MFP participants to discharge planning.	The Transition Coordinator (TC) is the first point of contact for people interested in leaving the nursing facility and participating in MFP. In this demonstration, the TC becomes the lead person in educating the person about MFP, assessing their needs and eligibility for MFP, making connections to approved housing, and community based services, including a Choices for Care case manager who will coordinate all ongoing care planning and CFC services after discharge. The TC will utilize the nursing facilities' existing MDS information to identify current care needs. The TC will complete a Choices for Care clinical assessment with the individual if needed to confirm continued CFC clinical eligibility and will complete the initial Independent Living Assessment (ILA) and care plan for community based services. The TC will have similar qualification as the existing RN, Long-Term Care	Revision to OP: Section C, pg 123 of tracked changes document.

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
		Clinical Coordinators who administer the clinical eligibility and utilization review for the Choices for Care program. <i>See attached job description.</i>	
4	(Page 31-32 of 270) The State has identified a strong reliance upon the addition of the new Adult Family Care service to Choices for Care to address two of the three gaps identified (24 hour supervision and supports for individuals with BH needs). Where is this new service? Please provide an assurance that sufficient numbers of these providers are/will be available both to transition MFP participants, and to meet the needs of non-MFP Choices for Care beneficiaries.	The Adult Family Care service will be developed through the MFP demonstration grant. Vermont has experienced a lot of interest in this model from providers who want to participate in providing the service, consumers who want to participate in the option and advocates who feel it would be a valuable service to fill an existing unmet need. We are confident that once the service is developed there will be sufficient providers to meet the needs of eligible MFP and Choices for Care participants.	Revision to OP: Project Abstract & Profile, pg 1 of tracked changes document.
5	(Page 28 of 270) Please submit job descriptions when they are final.	Done. See attached.	NA
6	(Page 36 of 270) Proposal describes intent to contract with non-service providers to serve as transition consultants. Please explain their role.	DAIL has removed the Transition Consultant contract from the grant in order to meet the CMS required 20% administrative cap. All reference to the Transition Consultant contract was removed from the OP.	Revision to OP: Pages 8, 13, 14, 22, 121, 133 of tracked changes document.
Benchmarks			
7	(Page 42 of 270) Benchmark 5 appears to be a measure of success of the MFP demonstration and perhaps belongs as part of the evaluation. It does not appear to be a benchmark as described in our guidance. Please explain how this benchmark measures the progress made by the State in directing savings from the enhanced FMAP towards rebalancing.	Operational Protocol narrative has been expanded to explain how the optional benchmarks measure the state's progress in directing enhanced FMAP savings toward rebalancing of the long term care system.	Revision to OP: Section A.2, pg 20 of tracked changes document.
8	(Page 40-42 of 270) Benchmarks 3 & 4 are not related to rebalancing. #3 is a function of Benchmark #1. Please revise benchmarks to address rebalancing and please explain how the rebalancing funds will be used.	Benchmark 3 has been replaced with new benchmark measuring utilization of new housing alternative (Adult Family Care). Operational Protocol narrative has been expanded to explain how the optional benchmarks measure the state's progress in directing enhanced FMAP savings toward rebalancing of the long term care	Revision to OP: Section A.2, pg 18 & 19 of tracked changes document.

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
		system.	
9	(Page 15 of 270) Benchmark 2: Qualified HCBS Expenditures. It is recommended that the state expand the narrative for this benchmark to clarify which categories of HCBS spending are and are not included in the projected annual HCBS qualified expenditures targets. In addition, it would be helpful to better understand what factors led Vermont to base the future expenditure projections on a trend rate of two percent.	Benchmark 2 includes expenditures for all Qualified HCBS expenditures. Trend rate is based on historical and projected program budget growth. Narrative has been revised to address both items.	<u>Revision to OP:</u> Section A.2, pg 17 of tracked changes document.
10	(Page 16-18 of 270) Benchmark 3-5 (Additional Benchmarks). Overall, Vermont's additional benchmarks support efforts to transition (and keep) more individuals to the community; however, it is recommended that the state include additional narrative to specify how these benchmarks will reinvest the state's funds from the enhanced FMAP to permanently affect the LTC system towards increased HCBS.	Operational Protocol narrative has been expanded to explain how the optional benchmarks measure the state's progress in directing enhanced FMAP savings toward rebalancing of the long term care system.	<u>Revision to OP:</u> Section A.2, pgs 18-20 of tracked changes document.
11	(Page 17 of 270) Benchmark 4 (Additional Benchmark - Inform MFP-Eligible Residents about the Program). If Vermont implements a MFP program, the state will be reporting progress on this benchmark into the web-based reporting system. It would be helpful to know if Vermont plans to report progress made under this benchmark in numbers or percents.	Narrative has been revised to clarify that reporting will be in actual numbers, not percents.	<u>Revision to OP:</u> Section A.2, pgs 19 & 20 of tracked changes document.
12	(Page 18 of 270) Benchmark 5 (Additional Benchmark - Increase Number of MFP Participants who Remain in the Community after One Year). Similar to the comment re: Benchmark 3, it would be helpful to know if Vermont plans to report progress made under	Narrative has been revised to clarify that reporting will be in actual numbers, not percents.	<u>Revision to OP:</u> Section A.2, pg 20 of tracked changes document.

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
	this benchmark in numbers or percents.		
13	In addition, it is recommended that Vermont expand the narrative to further explain who the state considers in the count of 'total transitioning residents' (the denominator). In other words, if the state plans to report 80 percent progress to this benchmark in CY 2011, will that be 80 percent of WHAT? Will it include all individuals that have transitioned during 2011, all individuals who have reached their one year mark during 2011, or something else?	Narrative has been revised to clarify that denominator is all transitioning residents in a reporting year (results will be calculated at close of second year, after all transitioning individuals have reached their one-year anniversary).	<u>Revision to OP:</u> Section A.2, pg 20 of tracked changes document.
14	The grantee should revise its targets to start reporting progress in 2012 since that is the expected year that individuals will start reaching their one year mark and then determining whether or not they will remain in the community.	Table has been revised to show 2012 as first reporting period.	<u>Revision to OP:</u> Section A.2, pg 21 of tracked changes document.
15	(Page 48-49 of 270) Please confirm that a determination of receipt of Medicaid services can be verified through Vermont's Medicaid Eligibility system. Please also describe any secondary verification process, if any, that may be used as a backup to account for claims lag.	DAIL currently has access to the VT Medicaid Eligibility and claims system. Individuals currently residing in nursing facilities with LTC Medicaid payment and eligible for MFP are already in the current Choices for Care (CFC) LTC Medicaid system. In addition, the individuals and their services are currently tracked in the existing SAMS program database. In addition to the Medicaid claims system, Transition Coordinators will have access to the SAMS database to confirm enrollment in CFC LTC Medicaid for at least one full day. Transition Coordinators will also be on site at nursing facilities, giving them the ability to verify the start of LTC Medicaid payment via the nursing facility business office. Clarified language in section <u>B.1 Participant Recruitment and Enrollment</u> of the Operational Protocol.	<u>Revision to OP:</u> Section B.1, pg 28 of tracked changes document.
16	(Page 50 of 270) Please describe the State's	Added language to this section as it appears in Appendix D.	<u>Revision to OP:</u> Section

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
	policy for re-enrollment in the demonstration for a participant who is readmitted to a facility prior to completion of 12 months of demonstration services, and who is readmitted for a period of time greater than 30 days. (There is some mention in the informed consent form in Appendix D of multiple 30-day occurrences and potential disenrollment.)		B.1, pgs 29 & 30 of tracked changes document.
17	(Page 67 of 270) Please explain the statement that the guardian must "visit the facility in which the ward is to be placed if it is proposed that the ward be placed outside his or her home". Is the term "facility" inclusive of non-institutional settings such as assisted living or adult foster care?	For the purpose of MFP, guardians will be required to visit any new residential setting of their ward, including assisted living or adult family care.	NA
18	(Page 43 of 270) Please clarify whether transition coordinators will be DAIL employees and when a job description will be completed.	Transition Coordinators will be DAIL employees. See attached job description.	NA
19	(Page 44 of 270) Please add that participants must be Medicaid recipients for at least one day prior to transition, although it's stated elsewhere.	Added a bullet to this section regarding this requirement.	Revision to OP: Section B.1, pg 23 of tracked changes document.
20	(Page 45 of 270) Please describe the purpose of the consultation with the facility discharge planner and whether/how it leads to contact with the resident.	There are several reasons the Transition Coordinator will consult with the facility discharge planner: 1) to identify potentially eligible individuals, 2) as a professional courtesy when a resident has expressed interest in MFP, 3) to collaborate on discharge planning for eligible MFP residents.	NA
21	(Page 47- 49) Please clarify that the purpose of the qualified residence form is to explain the available residences. Is the transition assessment based on the ILA? If not, has it been developed or when will it be developed.	The Qualified Residence form is intended to both explain/list the different MFP qualified residences and to document the person's choice when the decision is made. Yes, the ILA will be used in combination with the existing MDS to create a transition plan.	NA

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#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
Informed Consent and Guardianship			
22	(Page 60+ of 270) (general) Please identify the State agency/unit responsible for receiving and reviewing critical incident reports, responding to problems concerning critical events, and investigation consumer complaints regarding violations of their rights.	The Quality Management Specialist (QMS) in the DAIL Division of Disability and Aging Services, Adult Services Unit will be responsible for receiving and reviewing critical incident reports for MFP. The VT long-term care Ombudsman program manages complaints regarding all long-term care services and settings. In addition, complaints received at DAIL regarding MFP participants will be received and processed by the QMS. <i>See section c. of B.6 Consumer Supports, regarding complaints.</i>	NA
Outreach/Marketing/Education			
23	(Page 63, 68 of 270) Please advise into which other languages, if any, the educational and outreach materials will be translated.	Education and outreach materials will be translated into any language upon request.	NA
24	(Page 67 of 270) Please provide a staff training schedule, including provisions for new staff that enter the MFP program post-implementation (after the initial 4-6 week training period has ended). Please also include an estimated timeline for development of educational/marketing materials.	Updated Operational Protocol to reflect training schedule. Given the relatively small numbers of MFP staff, new employees that enter the MFP program post-implementation will be provided similar one-on-one training using the same curriculum. OP has been updated to reflect that the educational/marketing materials will be developed by the Project Director within 30-days after the hire of the Project Director.	Revision to OP: Section B.3, pg 39 and Section C, pg 123 of tracked changes document.
25	(Page 60 of 270) Please clarify who will be responsible for developing the materials.	The Project Director. See #24.	Revision to OP: Section B.3, pg 39 of tracked changes document.
26	(Page 61 of 270) Please explain the time line for developing the materials.	See #24.	NA
27	(Page 62 of 270) Please explain the vehicle for covering the topics listed. Training?	The vehicles will be a combination of written, electronic and face-to-face.	NA
28	(Page 63-65 of 270) Please describe will be responsible for implementing the mass media and other activities and describe the time line.	The Project Director. See #24.	Revision to OP: Section B.3, pg 39 of tracked changes document.
29	(Page 74 of 270) Please describe how are consumers supported to attend meetings? Are materials sent in advance? Are support services available?	The Project Director will make meetings convenient to consumers by considering the location, the time of day and partnering with consumer advocacy & service organizations who can arrange support services if needed. Materials will be sent in advance.	NA

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
Stakeholder Involvement			
30	(Pages 45-53 of 270) Please provide details on the efforts the State plans to make to engage select MFP participants in the MFP Advisory Board and ad hoc committee. For instance, will travel reimbursement or meal vouchers be available, or other incentives used?	The DAIL Advisory board, that currently has consumer involvement, will continue to provide a role in the ongoing development of the MFP program. The Project Director will solicit requests to engage MFP participants when the MFP ad hoc committees are developed. This will happen via communication with MFP Transition Coordinators, case managers and service providers. In addition, will request that a previously convened workgroup for Adult Family Care continue their role with the addition of MFP participants. Currently, DAIL offers meals and travel reimbursement to consumers who participate on boards and workgroups. This will continue.	NA
31	(Page 74 of 270) Describe how consumer participation will be supported so they may attend meetings; provide input such as receiving materials in advance of meetings, and availability of supports if needed, stipends.	See #30.	NA
Benefits and Services			
32	(Page 78 of 270) Please provide additional detail on the Choices for Care option, which is described as a managed care waiver using a fee-for-service delivery system. Is this a PCCM model?	Choices for Care is Vermont's statewide Section 1115 managed long term care waiver. MFP participants will be enrolled in Choices for Care both prior to, and during their participation in the demonstration. Choices for Care does not utilize capitated health plan contracts. It also is not a PCCM model. Detailed information on the waiver is available in the Choices for Care operational protocol.	NA
33	(Page 80 of 270) Clarify whether there are waiting lists for high need applicants and if so how they will be addressed.	There is currently no waiting list for high needs applicants. In addition, all MFP participants will be a current CFC LTC Medicaid nursing home participant, which makes them automatically eligible to continue on CFC in the community as long as they meet high or highest needs clinical eligibility.	Revision to OP: Section B.10, pg 114 of tracked changes document.
Consumer Supports			
34	(Page 87 of 270) Please provide additional information on the anticipated or desired frequency of reporting to the QM specialist the	Reports will be submitted monthly. Updated OP to reflect this clarification.	Revision to OP: Section B.6, pg 69 of tracked changes document.

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
	number and type of participant calls for critical backup.		
35	General: Please describe the transition coordinators' qualifications and expected ratio of coordinator to MFP participant.	Transition Coordinators will be registered nurses. It is anticipated that each Transition Coordinator will help approximately 15-25 people transition from nursing facilities over the course of a year. See attached job description for more details on job tasks and qualifications.	NA
36	(Pages 86-87 of 270) Please describe who will train the VT 211 staff and when it will be completed.	VT 211 will be trained by the Project Director with help from other MFP staff as appropriate. Training will occur before the first MFP participant is transitioned to the community. Updated OP to reflect this clarification.	Revision to OP: Section B.6, pg 69 of tracked changes document.
Self Direction			
37	(Page 95 of 270) Please discuss the qualifications of the case manager and consultant with respect to making a determination of the participant's cognitive ability and ability to communicate effectively.	Case managers and consultants are trained by their respective agencies and through the statewide case management training curriculum on general assessment skills and how to complete required program assessment tools and forms. Case managers and consultants are not expected to make a clinical determination or diagnosis of cognitive impairment. Instead, they document how the person functions day-to-day, the person's ability to communicate to others effectively, whether they have a legal guardian and their ability to manage the required tasks associated with being an Employer (hiring, firing, training, scheduling and managing timesheets). The CFC "Employer Certification" form is completed by the case manager or consultant. This helps determine if the person is "eligible" to be an employer under the current CFC guidelines. Added clarifying language to this section of the OP.	Revision to OP: Section B.7, pg 75 of tracked changes document.
Quality			
38	(Page 111 of 270) The back- up proposal indicates that the participant handbook will include information about whom to call for 24 hour back up services. Please list the organizations, other than VT 211 that will be included in the list. Please describe how the	The current CFC Participant Handbook will be updated prior to transitioning the first MFP participant to include the MFP 211 backup system and other applicable MFP contacts. The Handbook already includes the CFC case management agency numbers (Area Agencies on Aging and Home Health Agencies) and other important numbers such as the Ombudsman and Adult Protective	NA

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
	state will monitor timely response to emergency back- up calls; track and document the number and type of calls and use the information in the QMS.	Services. VT 211 will submit reports to the Quality Management Specialists on a monthly basis to include response times. See response #34 and #36.	
Housing			
39	(Page 126 of 270) Please clarify whether the transition coordinator or another DAIL employee approves the documentation of the qualified residence.	The Transition Coordinator will review and approve the documentation of qualified residences. Updated OP to reflect this clarification.	Revision to OP: Section B.9, pg 108 of tracked changes document.
40	(Page 129) Please describe any existing relationships between DAIL and housing agencies and whether any housing agencies have waiting lists and do they include preferences for people with disabilities.	DAIL has a long history of developing housing initiatives for elderly and people living with a disability, such as Housing and Supportive Services (HASS). Currently, most congregate/subsidized housing authorities in VT have a waiting list for apartments. Therefore, DAIL will continue to reinforce the relationships with these housing authorities via the Community Development Specialists as well as developing a new LTC alternative called Adult Family Care.	NA
Continuity of Care			
41	(Page 32 of 270) The narrative states that high needs individuals are served by the Choices for Care waiver "to the extent funding is available". Please explain what happens to these individuals if funding is not available.	There is currently no High Needs wait list for new Choices for Care (CFC) applicants. In addition, it is anticipated that all new MFP participants will already be enrolled on Choices for Care in the nursing facility receiving LTC Medicaid when they are identified as MFP participant. Individuals who are currently enrolled on CFC will continue enrollment as long as they meet High or Highest Needs clinical criteria. Added clarifying language to the OP.	Revision to OP: Section B.10, pg 114 of tracked changes document.
Budget and Budget Narrative			
42	(Page 15 of 270) per capita admin costs are greater than 440% of per capita service costs? Please explain why expenditures for qualified HCBS are so low.	This error in per capita calculations was fixed in the January, 2011 revised budget. Attached revised budget worksheet and corrected op.	Revision to OP: Section E, pg 129, 134 & 135 of tracked changes document.
43	(Page 110 of 270) Please indicate which DAIL unit manages Choices for Care and how	The Adult Services Unit in the Division of Disability and Aging Services manages Choices for Care. MFP will be managed in the	Revision to OP: Pages 115, 117 and 122 of

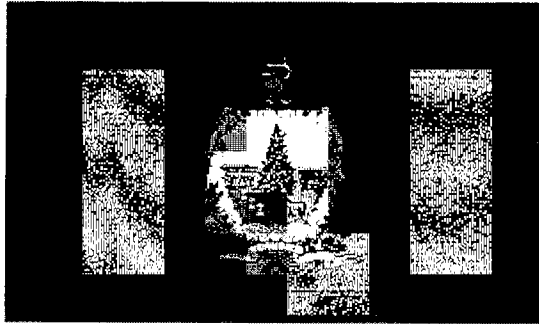
MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
	coordination between CFC and MFP will occur.	same unit. The OP has been updated to reflect this change.	tracked changes document.
44	(Page 138 of 270) Please explain whether the community development specialists will be independent contractors or organizations and how they will be selected.	These will be two contracted positions hired through an RFR process. This may result in a contract with an individual or agency.	NA
45	(Page 141 of 270) When will the billing code for demonstration services be established?	The billing code will be developed prior to the implementation of MFP services. DAIL will work with HP to identify needed codes.	NA
46	(Page 145/152 of 270) The estimate for qualified HCBS expenditures should be verified for data entry errors. It seems unlikely that the per capita service cost could be so low, only \$711 per participant, and less than 1/3 of expenditures for demonstration services.	This error in per capita calculations was fixed in the January, 2011 revised budget. Attached revised budget worksheet and corrected op.	Revision to OP: Section E, pg 129, 134 & 135 of tracked changes document.
47	VT has outstanding documents that need to be corrected and resubmitted prior to grant approval (Federal Funds Only Worksheet and 424a form). They will also need to address the inconsistencies in their Per Capita calculations. The Per Capita Administrative claims requested is not supported by the service costs and the number of persons they intend to serve.	This error in per capita calculations was fixed in the January, 2011 revised budget. Attached revised budget worksheet and 424a and corrected op.	Revision to OP: Section E, pg 129, 134 & 135 of tracked changes document.
48	Grantee will be required to submit a revised staffing plan, budget narrative, SF-424a form (Sections b and c), and Worksheet for Proposed Budget form that reflects the 1 st year spending at \$2,123,975, and total amount from 2011-2016 of 17,936,059. Administrative budget may <u>NOT</u> to exceed \$3,592,612 or 20% on total program budget.	The 20% administrative cap was not indicated in the MFP RFP, therefore this cap was not reflected in the DAIL application budget. DAIL also discovered that the application budget was created using the incorrect FMAP due to a misinterpretation of the worksheet instructions. DAIL has updated the OP and revised the budget to reflect the following: <ul style="list-style-type: none"> - corrected the enhanced FMAP - reduced the administrative budget by removing the Transition Consultant contract - pro-rated the first and last year of the other contracted services to more accurately reflect the partial CY11 and CY16 budgets. - adjusted the 5% indirect admin cost accordingly 	Revision to OP: Section E, pg 129, 134 & 135 of tracked changes document.

MFP Vermont Specific Terms and Conditions with Responses (4/1/11)

#	CMS Terms & Conditions	VT Responses	OP Page/Section Reference
		<p>- changed the projected start date to June 1 - changed the projected enrollment number for CY11 (and subsequent years) to more realistically reflect the later start date.</p> <p>NOTE: DAIL requests that CMS accept the revised administrative budget at \$3,838,371 (21% of \$17,936,059).</p>	

**The Vermont
Money Follows the Person Rebalancing Demonstration
Operational Protocol**



Submitted by:

State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living

DRAFT 4/1/2011

CFDA 93.791

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Appendices

Appendix A: Choices for Care Employer Handbook for Self-Direction

Appendix B: Draft MDS 3.0 Section Q Protocol and Referral Form

Appendix C: Choices for Care Participant Handbook

Appendix D: Draft Informed Consent Form

Appendix E: Letters of Endorsement

-- Choices for Care Client

--HomeShare Vermont

--State of Vermont Department of Mental Health

--Vermont Center for Independent Living

--Community of Vermont Elders

--DAIL Advisory Board

--Vermont Association of Area Agencies on Aging

Appendix F: Choices for Care Emergency Contacts and Back-up Plan

Appendices (continued)

Appendix G: Sub Appendix 1 - Self-Direction Submittal Form

Appendix H: Draft Incident Report Form

Appendix I: Project Director Job Description

Appendix J: MFP Maintenance of Effort Forms

Appendix K: Sub Appendix IV - Worksheet for Proposed Budget

PROJECT ABSTRACT AND PROFILE

The one-page abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, the number of projected transitions, and a description of how the grant will be used to help rebalance the State's LTC system

The state of Vermont is pleased to submit this application to participate in the Money Follows the Person Rebalancing Demonstration. The demonstration will be an integral component of Choices for Care, the state's groundbreaking Section 1115 long-term care waiver developed in 2005 in collaboration with CMS and recently renewed for another five-year term.

Under Choices for Care, Vermont has made significant strides in expanding placement options for long term care beneficiaries; over 60 percent of program enrollees are now served in home- and community-based settings. The state proposes to use demonstration funding to re-balance the long-term care system further by targeting older adult nursing facility residents and residents with physical disabilities who qualify and wish to return to the community.

Vermont's goal is to eliminate barriers to transition identified during extensive stakeholder outreach conducted in 2010. The state will introduce a one-time transition payment as a demonstration benefit and the development of Adult Family Care as a new Qualified HCBS setting, available to all Choices for Care participants. Progress will be measured by the number of residents who learn of the demonstration and the portion who transition with the state's assistance and remain in the community for at least one year.

PROJECT ABSTRACT AND PROFILE

The demonstration will be operated statewide and is projected to transition 375 unduplicated participants. The total projected combined budget for the demonstration is \$20,940,037..

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A. PROJECT INTRODUCTION

A.1 Organization and Administration

Part #1 - Systems Assessment and Gap Analysis

1. A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives that have affected the system. What State legislative and/or regulatory changes need to be made to further rebalance the LTC system and promote HCBS?

Introduction

The state of Vermont has been a leader in promoting person-centered services for individuals in need of long-term care. In 2005, Vermont collaborated with CMS in development of Choices for Care, the state's groundbreaking Section 1115 long-term care research and demonstration waiver program.

One of the primary goals of Choices for Care is to provide participants with equal access to long-term care options in community and institutional settings, while preventing unnecessary use of nursing facility care by elders and adults with disabilities who have functional impairments.

Vermont has made significant progress toward achieving this goal. In State Fiscal Year (SFY) 2010, approximately 60 percent of older adult beneficiaries and person with disabilities were served in home and community settings, up from only 34 percent in SFY 2006.

Vermont's progress over the past five years has positioned the state to focus on one of the most challenging groups within Choices for Care: longer stay nursing facility residents who desire to return home or to another community alternative. Although many former nursing facility residents have returned to the community under Choices for Care, there are longer stay

residents throughout the state who face barriers to discharge related to lack of initial transition supports and other services necessary to address their complex needs.

Vermont's Money Follows the Person (MFP) demonstration application is targeted at removing these barriers. Upon approval of Vermont's operational protocol, the state will embark on a variety of new rebalancing initiatives intended to complement Choices for Care, and ultimately expand service and placement options for all waiver-eligible persons.

Current Long-Term Care Support Systems

Vermont's current long-term care support systems are described below. The support systems for all long term care populations are described, beginning with older adults and persons with physical disabilities (addressed as one group) and finishing with a discussion of systems serving persons with mental health needs and persons with intellectual disabilities. Section 1 of the application concludes with a review of legislative and regulatory requirements for the demonstration.

Older adults/Persons with Physical Disabilities - Vermont's long-term care population, including older adults and persons with physical disabilities, is served through the Choices for Care waiver which is managed by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) within the Vermont Agency of Human Services. Participants are offered three program options: Home-Based Supports, Enhanced Residential Care and nursing facility care. Home-Based Supports, in turn, has five distinct alternatives: agency directed care,

consumer directed care, surrogate directed care, Flexible Choices and PACE. Consumer and surrogate directed care are both employer-authority options while Flexible Choices is a budget-authority option. Enhanced Residential Care (ERC) services includes both licensed Level III Residential Care Homes and Assisted Living Residences.

Individuals in home- and community-based placements receive services in accordance with person-centered care plans. MFP demonstration participants will be enrolled in Choices for Care and will have available the same menu of qualified HCBS services, including case management, personal care, respite care, companion care, adult day services, assistive devices, home modifications and personal emergency response systems. Individuals living in Level III Residential Care Homes and Assisted Living Residences pay for room and board and receive 24-hour care and oversight with a tiered daily ERC reimbursement rate from Medicaid.

Mental Health - Mental (behavioral) health services are provided through private, non-profit community mental health centers, known in Vermont as Designated Agencies (DA's). Each DA has a defined geographic jurisdiction within which it is responsible for ensuring needed services are available. The programs offered through the DA's include Community Rehabilitation and Treatment for persons with serious mental illnesses, Adult Outpatient and Emergency/Crisis services. The DA's are responsible for providing behavioral health services to Choices for Care enrollees living at home or another community setting.

Persons with Intellectual Disabilities - All Vermonters with intellectual disabilities are served in community settings. Supports are provided by private non-profit developmental disability service providers throughout the state. Individuals or their families may also choose to self- or family-manage their own services with the assistance of an Intermediary Service Organization.

Legislative and Regulatory Changes

There are no legislative actions required to implement the MFP demonstration or offer any of the new services described below. Adult Family Care, which would be a new Qualified HCBS service, already is authorized in statute.

Vermont also does not believe that an amendment to the Choices for Care waiver will be required to implement any portion of the MFP demonstration. However, the state will consult with CMS immediately upon grant award to verify this is correct. If an amendment is deemed necessary, the state will submit the amendment within 30 days and will work closely with CMS to complete the amendment process. In the interim, DAIL will proceed to implement as much of the demonstration as can be accomplished under the existing waiver, including hiring of staff and contracting with providers in anticipation of the go live date.

Job descriptions for the new positions identified below will have to be created and regulations will have to be promulgated for the new benefits proposed under the demonstration. DAIL will commence both activities upon grant award to ensure timely implementation.

2. An assessment of what Medicaid programs and services are working together to rebalance the State's resources and a description of any institutional diversion and/or transitions programs or processes that are currently in operation. What additional Medicaid programs and services are needed to increase HCBS and decrease the use of institutional care?

Current programs and services

Vermont residents currently transitioning from a hospital or nursing facility to the community receive outreach first from a hospital or nursing facility discharge planner. They also can be referred from a residential setting by family members, caregivers, guardians, local Aging and Disability Resource Centers (ADRCs) and advocates. Once referred, the resident must meet financial and clinical criteria to be found eligible.

Choices for Care case managers are responsible for working with nursing facility discharge planners to plan and carry out the transition back to the community. Although this process works relatively well for residents with less complex needs, it is not ideal for individuals with complex needs. There is no formal program (infrastructure) in place for transition and placement of complex, longer-stay residents.

Additional Medicaid Programs and Services needed to Increase HCBS

During the summer and fall of 2010, DAIL representatives met with private and public stakeholders throughout the state to document barriers to discharge for longer stay nursing facility residents. In addition to an enhanced transition infrastructure and process, stakeholders identified the need for one-time financial assistance to cover expenses associated with relocating to the community; service settings that include 24-hour supervision; and

appropriate supports for persons with behavioral health needs. The proposed supports and services are delineated below.

Transition Coordinators – Vermont will create the position of Transition Coordinator, to be located within DAIL and devoted to the MFP demonstration. Transition Coordinators will be responsible for doing all of the following:

- Making visits to nursing facilities across the state to screen and identify individuals eligible for the MFP demonstration;
- Responding to MFP referrals from nursing facilities, residents (self-referrals), families, guardians and others; undertaking comprehensive transition planning for all eligible MFP participants;
- Performing transition assessments (including a comprehensive risk assessment);
- Developing individualized plans of care in collaboration with the participant and the participant’s assigned case manager;
- Collaborating with the participant’s case manager and Community Development Specialist (described below) to arrange and coordinate services pre-transition;
- Performing discharge planning functions in coordination with the nursing facility; and carrying out post-transition follow-up calls and visits as necessary to ensure implementation of the plan-of-care and to identify any unmet needs that could pose a risk of re-institutionalization.

Deleted: at least 90 days prior to discharge

Comment [WU1]: The transition consultant contract was removed in order to comply with the CMS 20% admin cap.

Deleted: Transition Consultants– The state also will contract with organizations having special expertise in addressing the needs of transitioning participants

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Deleted: , such as the Center for Independent Living, Area Agencies on Aging, HomeShare Vermont and the Designated Agencies, to serve as consultants to the transition teams. Representatives of the organizations will be available as a resource on a case-by-case basis, as well as to advise the state on broader transition strategies. ¶

Community Development Specialists – Every demonstration participant, through their Transition Coordinator, will have access to a Community Development Specialist responsible for identifying appropriate housing alternatives and linking participants to other community support services, such as transportation. In addition to their participant-specific activities, Community Development Specialists, who will be contracted staff, will work to increase total alternative housing capacity. They also will conduct extensive marketing and outreach activities and provide training on program eligibility requirements and policies and procedures to MFP staff, HCBS providers and nursing facilities.

Transition Payment – To assist individuals in defraying transition costs not covered through other waiver services, a one-time set-up payment of up to \$2,500 will be provided. Transition payments will be furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. Transition payments will be used to pay for a variety of items and services, including but not limited to: security deposits, home access modifications, utility deposits, pest eradication, household goods, household setup and food stocking.

Adult Family Care - Adult Family Care consists of an adult home established and operated for the purpose of providing long-term residential care (room, board, housekeeping, personal care, and supervision) in an environment that is safe, family oriented, and designed to maintain a high level of independence and dignity for the resident. Adult Family Care will be an addition to the current menu of Qualified HCBS available under Choices for Care. Adult Family Care will

resolve a barrier to transition that currently exists by enabling more participants who require 24-hour supervision to move to a community setting. Homes will serve one to two residents.

Mental Health Programs – A portion of the nursing facility population to be transitioned under the demonstration have both behavioral and physical health needs. DAIL, the Department of Mental Health (DMH), the Designated Agencies, Area Agencies on Aging and other stakeholders will collaborate in developing long-term strategies to ensure availability of appropriate support services. One approach under consideration would be to create a “behavioral health specialist” certification for Adult Family Care home providers who complete necessary training, and to pay these providers a higher rate.

3. A description of the number of potential participants who are now living in institutions including the number of residents in nursing homes who have indicated they would like to transition into the community.

DAIL undertook a feasibility analysis in the summer and fall of 2010 to evaluate the potential size of the MFP-eligible population. The analysis was conducted through onsite interviews with administrators and discharge planners at nursing facilities located throughout the state.

Exhibit 1 below identifies the number of MFP-eligible residents, segmented into the CMS defined populations. The facilities visited during the feasibility analysis contained 39 eligible residents and, coincidentally, represented 39 percent of the total Medicaid nursing home population, resulting in a statewide estimate of 100. The 2011 figure is projected to increase by five residents per year, based on historical growth rates and consultation with stakeholders.

Exhibit 1 – Estimate of MFP-Eligible Nursing Facility Residents by Category

Calendar Year	Older adults	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total
CY 2011	86	-	14	-	-	100
CY 2012	90	-	15	-	-	105
CY 2013	94	-	16	-	-	110
CY 2014	98	-	17	-	-	115
CY 2015	102	-	18	-	-	120
CY 2016	106	-	19	-	-	125

4. A description of any current efforts to provide individuals with opportunities to self-direct their services and supports. Would your State be developing additional opportunities for participants to self-direct?

Choices for Care offers three options to individuals who wish to self-direct their services and supports: consumer directed, surrogate directed and the Flexible Choices Program. In the home-based setting, Choices for Care offers three services that may be directed by the individual or a surrogate employer: personal care, respite care and companion services.

If an individual who is participating in Choices for Care is able and willing to be an employer for their own personal care, respite or companion services, they may apply for the consumer-directed option. However, if the individual is not able or willing to be the employer, a trusted friend or family member may apply to be the surrogate-directed employer.

The Flexible Choices option within Choices for Care is based on the belief that consumers and their families know best how to meet the needs of individuals residing at home. Flexible

Choices offers consumers an allowance, which is based on their needs and the value of their Choices for Care home-based service plan.

MFP demonstration participants will be afforded the same options to self-direct their services as other Choices for Care enrollees. MFP participants will be counseled by the Transition Coordinator at the time of enrollment about the three self-direction options. As in the current program, case managers will be responsible for training and assisting individuals to understand the obligations and procedures of self-direction. An employer handbook has been developed for Choices for Care and will be distributed to all MFP participants who wish to self-direct. A copy of the handbook is included in Appendix A of the application.

5. Describe the stakeholder involvement in your LTC system. How will you include consumers and families as well as other stakeholders in the implementation of the MFP demonstration?

Vermont involves both private and public stakeholders in oversight and evaluation of the Choices for Care program. The state contracts with the University of Massachusetts to conduct an independent evaluation of the program, including documenting stakeholder perceptions through surveys and other primary research.

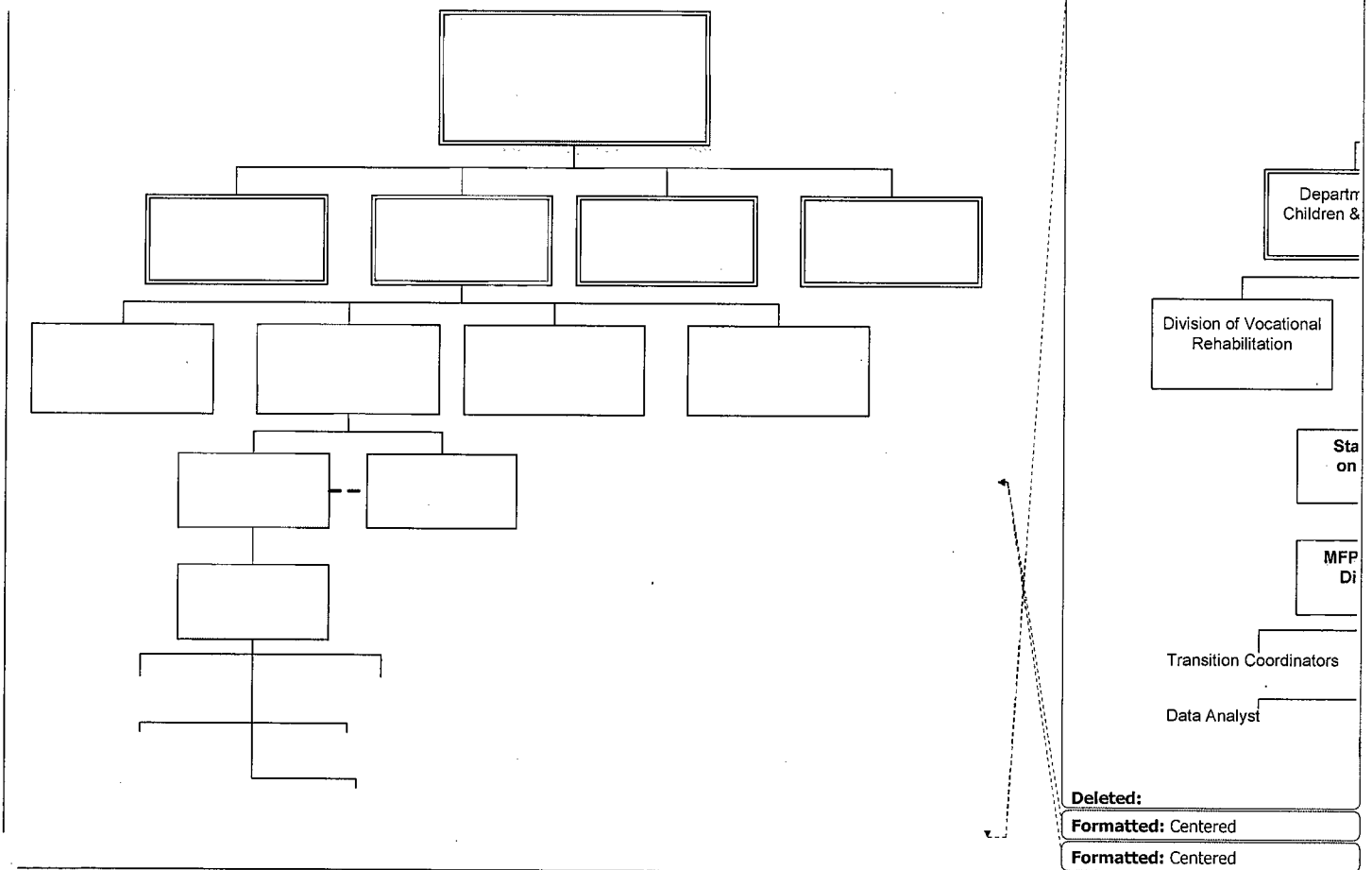
The state also involves consumers through the Department Aging and Independent Living (DAIL) Advisory Board. The Board's composition and duties are described in greater detail in Section B.4 of the application. Consumers, families and other stakeholders will be consulted on the implementation of the MFP demonstration through both the DAIL Advisory Board and an ad hoc committee of stakeholders also described in Section B.4.

Description of the Demonstration's Administrative Structure

Describe the Administrative structure that will oversee the demonstration. Include the oversight of the Medicaid Director, which agency will be the lead agency, all departments and services that will partner together, the administrative support agencies that will provide data and finance support and what formal linkages will be made and by what method, (i.e. Memorandum of Agreement, reorganization).

Exhibit 2 below presents an organizational chart depicting the relationships among the various partners who will be involved in the demonstration.

Exhibit 2 – Administrative Structure for Vermont's MFP demonstration



The Agency of Human Services (AHS) is the single state agency for Medicaid in Vermont, and has the overall responsibility for the MFP demonstration program. The Department of Vermont Health Access (DVHA) within AHS is responsible for administration of the Medicaid program and is headed by the Medicaid Commissioner.

The Department of Disabilities, Aging, and Independent Living (DAIL) will be the lead agency for the MFP demonstration within AHS. ~~Megan Tierney-Ward, Medicaid Waiver Supervisor, in the Adult Services Unit, will act as the interim Project Director until a permanent director is hired.~~
The search for a permanent director will commence upon grant award.

Deleted: Camille George
Deleted: Director, State Unit on Aging

In addition to the Project Director, the MFP component of DAIL will house Transition Coordinators, Community Development Specialists (contracted staff), QM Specialists, a Data Analyst and an Administrative Assistant.

Comment [WU2]: The transition consultant contract was removed in order to comply with the CMS 20% admin cap.
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As previously described, DAIL also will contract with organizations that do not act as direct service providers to serve as Transition C
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Deleted: Transition Coordinators. These will likely include a combination of the Vermont Center for Independent Living, Area Agencies on Aging, Designated Agencies, State Independent Living Council, HomeShare Vermont and other local organizations familiar with Vermont's supportive home- and community-based services.¶

Partnering agencies will include the Department of Vermont Health Access (DVHA), Department of Mental Health (DMH) and Department for Children and Families (DCF). DVHA and DMH have been involved in the design and development of the demonstration model and will continue to play an active role as it is implemented. DCF is responsible for performing financial eligibility determinations for Choices for Care participants. Because all of the departments reside within AHS, no memorandum of understanding or other intergovernmental agreement will be necessary to codify their responsibilities.

Operational and financial data reporting activities will be performed by the MFP Data Analyst hired for this purpose through the demonstration. This individual will coordinate financial reporting on the CMS-64 with AHS Business Office. As the state office responsible for the management of Medicaid and other publicly funded health insurance programs in Vermont, DVHA also will be instrumental in assisting with cost avoidance activities.

A.2 Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. In the application, two specific benchmarks were required by all awardees. These two benchmarks are:

- Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.
- Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.

To assess Vermont's progress in transitioning individuals to the community and rebalancing its long-term care system, the state will measure the progress of five benchmarks on an annual basis. Each calendar year, we will collect data for two benchmarks required by CMS and for three benchmarks proposed by Vermont. The two required benchmarks follow.

Benchmark 1 – (Required) Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration

Exhibit 3 below presents the projected numbers of MFP-eligible individuals (by target population group) who will be assisted to transition to qualified residences in each calendar year of the demonstration. The projection is based on a target transition rate equal to approximately 50 percent of eligible nursing facility residents in year one, increasing to 60 percent by year five. The state recognizes these are aggressive targets but believes they can be achieved by building on the success of the Choices for Care waiver.

A total of 25 residents are expected to transition from nursing facilities in Year 1, and a grand total of 375 unduplicated individuals will transition throughout the demonstration period.

Exhibit 3 – MFP-Eligible Residents by Target Group by Calendar Year

Comment [WU3]: Projected enrollments were revised to reflect a more realistic start date of no sooner than 6/1/11. They were also adjusted to prorate CY16.

CY 2011	23	-	2	-	-	25
CY 2012	60	-	10	-	-	70
CY 2013	65	-	10	-	-	75
CY 2014	73	-	12	-	-	85
CY 2015	77	-	13	-	-	90
CY 2016	26	-	4	-	-	30

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Benchmark 2 – (Required) Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program

Exhibit 4 below presents the projected increase in Medicaid support (spending) for home- and community-based long term-care services (all long-term care, not only MFP spending) for each calendar year of the demonstration. The expenditure projections are for the qualified HCBS benefits presented in Exhibit 10 on page 58 and include both state and federal dollars. Expenditures are increased at an annual rate of two percent, based on historical trends and projected program budget growth.

Exhibit 4 – Increase in Medicaid Expenditures for HCBS

CY 2011	\$56,890,315
CY 2012	\$58,028,121
CY 2013	\$59,188,684
CY 2014	\$60,372,457
CY 2015	\$61,579,906
CY 2016	\$62,811,505

Vermont proposes the following three additional success benchmarks to measure performance under the demonstration. As described in detail below, the benchmarks will serve to document the state's progress toward rebalancing Vermont's long term care system through reinvestment of enhanced FMAP savings.

Benchmark 3 – Increase in the number of participants who are transitioned to an Adult Family Care setting each year.

Exhibit 5 below projects the number of individuals who will be transitioned to Adult Family Care, a new qualified HCBS option being introduced under the demonstration. The state anticipates that Adult Family Care will fill an unmet need in the Choices for Care service continuum and play an important role in program rebalancing. Savings resulting from enhanced FMAP will support the growth in infrastructure and capacity through funding of additional AFC placements throughout the demonstration. The state projects that approximately one-third of all participants will transition to Adult Family Care.

Exhibit 5 - Participants Who Secure Housing through the Community Development Specialist

CY 2011	25	9	Deleted: 50
CY 2012	70	23	Deleted: 17
CY 2013	75	25	Deleted: 55
CY 2014	85	29	Deleted: 18
CY 2015	90	30	Deleted: 60
CY 2016	30	10	Deleted: 20
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Benchmark 4 - Increase in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program and who receive a transition packet each year.

This benchmark measures the number of Medicaid-eligible nursing facility residents who will be informed of the MFP demonstration and receive a transition packet each year. Its focus is similar to the CMS optional benchmark measuring utilization of transition coordinators to assist individuals in Medicaid find appropriate services and supports in the community. It differs in that it measures critical activities occurring earlier in the transition process.

Vermont believes the Transition Coordinator will play an essential role in generating awareness of the demonstration among nursing facility residents and their families, which is a necessary precursor to identifying and assisting demonstration participants. The distribution of transition packets will be a reliable benchmark for measuring the productivity and effectiveness of these individuals and their contribution toward program rebalancing and generation of enhanced FMAP savings for reinvestment. The benchmark will be tracked both at the individual level and in aggregate.

The state anticipates that Transition Coordinators will inform and disseminate transition packets to at least 85 percent of residents in the first year, climbing to 95 percent by year five, as shown in exhibit 6 below. (The State will report results based on the actual number of persons educated about the program rather than the percent.)

Exhibit 6 - Number of MFP-Eligible Residents Educated about the MFP Program

Year	Number of MFP-Eligible Residents	Percentage Educated
CY 2011	100	85 (85 percent)
CY 2012	105	91 (87 percent)
CY 2013	110	98 (89 percent)
CY 2014	115	105 (91 percent)
CY 2015	120	112 (93 percent)
CY 2016	125	119 (95 percent)

Benchmark 5 – 80 percent of the initial MFP participants will remain in the community for at least 1 year after transition and the rate will increase by two percent in each subsequent year

To succeed, the MFP demonstration must not only transition participants out of the nursing facility but also provide the necessary supports to keep the majority of these individuals in the community for at least one year. In addition, by consistently reaching this milestone, the state will maximize the enhanced FMAP available for reinvestment toward further program rebalancing.

The state has set a benchmark of 80 percent for the initial (year one) group of transitioning participants and will seek to increase the rate by two percentage points in each subsequent year. These targets are ambitious but the state believes its person centered care model is well suited to achieve this outcome. Exhibit 7 below presents for each calendar year the projected number of persons who will remain in the community one year after transitioning. Results for 2012 will be reported at the end of the year and will be based on all participants who transitioned in calendar year 2011. Subsequent years will follow the same methodology. (The State will report results based on the actual number of persons educated about the program rather than the percent.)

Exhibit 7 - Number of MFP Participants Who Remain in the Community after One Year

	Number of Participants	Number of Participants Remaining in Community after One Year
CY 2012	25	20 (80 percent)
CY 2013	70	57 (82 percent)
CY 2014	75	63 (84 percent)
CY 2015	85	73 (86 percent)
CY 2016	90	79 (88 percent)

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B. DEMONSTRATION POLICIES AND PROCEDURES

B.1 Participant Recruitment and Enrollment

Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, the Draft OP may include samples of a few recruitment and enrollment materials that will be disseminated to enrollees if developed. (please limit the pages of your application to those required) Your OP may include materials developed as appendices after the grant award is made and before the final approval of the OP

a. How will the service provider be selected and does the State intend to engage the State's Centers for Independent Living in some role in the transition process.

Participating service providers will consist of nursing facilities that have potential candidates for the MFP demonstration. There are approximately 2,000 Medicaid-eligible residents currently residing in Medicaid-participating nursing facilities across the state. Transition Coordinators will work with each of these nursing facilities to assess candidates for the MFP demonstration. Nursing facility staff will receive training about the MFP demonstration (refer to B.3.- Outreach/Marketing/Education for further information on training), including how to identify potential participants.

During the transition process, the Transition Coordinators will consult with organizations, such as the Area Agencies on Aging, Home Share VT, and the Vermont Center for Independent Living (VCIL). Vermont understands that Centers for Independent Living have performed similar tasks in other MFP demonstration states and fully expects the Vermont Center to participate as well.

The Vermont Center for Independent Living is a partner in Vermont's Aging and Disabilities Resource Connection project and already is playing an important role in supporting care transitions. Specifically, VCIL is serving as one of the Local Area Contacts for the MDS 3.0 Section Q discharge process for nursing homes. This expertise will be of great value to the state during the transition planning process for new MFP demonstration participants.

b. The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence. Please include a discussion of:

- the information/data that will be utilized (i.e., use of MDS Section "Q" or other institutional data);
- how access to facilities and residents will be accomplished
- the information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information

Criteria Used to Identify MFP Candidates

Eligible individuals will be those who meet all of the following conditions:

- Vermont resident
- Receiving nursing facility services
- Meets CMS requirements for 90 consecutive days in facility (excluding rehab days)

Comment [WU4]: The transition consultant contract was removed in order to comply with the CMS 20% admin cap.

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- Enrolled with Medicaid coverage for a minimum of one day prior to transition
- Expresses a desire to return to a community setting

Processes to Identify Individuals for Transitioning

The information/data and processes that will be utilized to identify individuals meeting these criteria are outlined below.

1) DAAL-Initiated Identification

The MFP Data Analyst will generate a monthly report from paid claims data identifying residents who may have become eligible for MFP in the past 30 days based on length-of-stay. The report will be provided to the Transition Coordinators, who will make monthly visits to all nursing facilities in their regions. During the visits, the Transition Coordinators will follow-up on the information and consult with facility discharge planners. The visits will be mandatory and will occur as part of the state's utilization review process.

2) MDS 3.0 Section Q

DAAL has established a process similar to other states whereby nursing facility discharge planners and nursing staff review the MDS 3.0 Section Q information to determine whether a referral to a Local Contact Agency (LCA) can be made. If an individual wishes to speak with someone about returning to the community, the nursing facility will complete the MDS 3.0 Section Q Referral Form (Appendix B includes a copy of the Vermont Section Q protocol and a draft MDS 3.0 Section Q Referral Form). The completed referral form will be submitted to the LCA (the Vermont Aging and Disability Resource Connection partner agency serving the county in which the nursing facility is located). Referral forms will be submitted within ten business

days of completion to the LCAs and nursing facilities will attach a copy to the resident's medical record.

Once a referral is made, the LCA will screen the individual to determine whether he or she meets the MFP criteria. If the person does appear to meet the criteria, the LCA will contact an MFP Transition Coordinator to schedule a visit with the MFP candidate within five business days. The Transition Coordinator will discuss the MFP demonstration with the candidate and provide an MFP transition packet if he/she has a desire to return to the community and meets the MFP eligibility criteria. If the individual does not meet MFP or Choices for Care criteria, then the Transition Coordinator will refer the individual back to the LCA for further assistance with discharge planning.

3) Resident Self-Referrals

Upon determination of an expressed interest to return to the community by a resident or his/her legal guardian, an MFP Transition Coordinator will be contacted. This initial contact may come from the Long Term Care Ombudsman, Office of Public Guardian, a community agency, family members, guardians, facility residents, nursing facility patient liaisons, social workers, or others who may have met with the resident.

Prior to visiting the resident, the Transition Coordinator will notify a designated contact person at the respective nursing facility that the individual has expressed an interest in transition. This

notification is conducted as a professional courtesy to facilitate entry and access to facility residents by MFP Transition Coordinators and/or case managers.

Information Provided to MFP Candidates

The following information will be provided to individuals and the greater community to explain the MFP demonstration, the transition process and the options available:

- **Transition packets** - Transition Coordinators will meet with the potential transition participant, family member, guardian, and/or significant others to provide a comprehensive overview of the MFP demonstration program and Choices for Care. They will disseminate transition packets to eligible individuals at each of the nursing facilities that include: (1) cover letter; (2) MFP application (referral) form with information about who to call; (3) MFP Informed Consent form; (4) Brochure and Fact Sheet; (5) Eligibility Information; (6) Choices for Care Participant Handbook; and (7) Qualified Residence Form. The Transition Coordinator will answer questions, address concerns, and establish methods for on-going communication (phone, email, face-to-face, etc.). The transition packets are intended to assist the individuals in making an informed decision about transition to the community.
- **Miscellaneous materials** - The Vermont MFP demonstration identification process will rely on referrals and one-on-one outreach in the manner similar to the existing 1115 long-term waiver, Choices for Care. DAIL staff will mail MFP participant packets to interested individuals when they call for information. (Transition Coordinators will deliver packets in person to residents who request the information.) DAIL also will

create an MFP page on its website to provide programmatic information and offer materials in other languages as necessary.

c. The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting. If targeting certain facilities, the names of the identified facilities and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

The MFP demonstration will not be limited by geography or other criteria. It will be open to eligible residents of any Medicaid-participating nursing facility in the state.

d. The minimum residency period to conform to the changes made to Section 6071 by the ACA reducing the minimum number of consecutive days to 90 in an institutional setting with the statutory exception noted in the ACA; and who is responsible for assuring that the requirement has been met.

DAIL will target individuals who have been residing in Vermont nursing facilities for 90 or more consecutive days, not including the period of time the individual may have been admitted solely for purposes of receiving short-term rehabilitative services. The Transition Coordinator assigned to the respective nursing facility will be trained to review this information through medical record reviews and interviews of nursing facility staff to assure that this requirement has been met as well as the other MFP eligibility criteria noted above.

e. The process (who and when) for assuring that the MFP participant has been eligible for Medicaid at least one day prior to transition from the institution to the community.

Transition Coordinators will be responsible for determining whether the MFP participant has been eligible for and receiving Medicaid services at least one day prior to transition from the nursing facility to the community. The verification will be done through the use of the Medicaid

Eligibility System, whereby the Transition Coordinator accesses the information through the online portal and documents it in the participant's case record. In addition, the Transition Coordinators will have access to the existing Choices for Care SAMS database, identifying individuals currently residing in nursing homes enrolled on the Choices for Care, Long-Term Care Medicaid program. Since they will frequently be on-site at nursing facilities, the Transition Coordinators may also verify the start of Medicaid coverage with the nursing facility business office as needed.

f. The process for determining that the provision of HCBS to a participant enables that participant to be transitioned from a qualified institution. Formal Level of Care determinations are not required prior to transitioning into the MFP demonstration for the 365 day period. States may elect to develop an assessment of eligibility that takes into consideration the readiness for an individual to transition into the community with identified transition services and appropriate long-term care services.

Transition Coordinators will perform a comprehensive transition assessment once it has been determined that a nursing facility resident meets MFP eligibility criteria and wishes to return to the community. The transition assessment is designed to evaluate the individual's readiness to transition into the community; assess the individual's level of risk; and identify his/her needs across several life domains including: safety, cognitive abilities, Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADL's), medical diagnoses, housing, financial, legal, community services, and informal and formal supports.

A determination will be made about the candidate's readiness to transition based on the transition assessment and risk assessment results. If the candidate meets transition criteria, the results of the transition assessment will be used to develop an individualized care plan and to

identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The Transition Coordinator, an assigned case manager and the MFP participant will work as a team to develop the care plan.

The care planning process also will include development of a contingency or “backup” plan for each service. The back-up plan will become part of the individual’s larger care plan.

g. The State’s policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.

Individuals readmitted to an institution, including a hospital, after completing 12 months of demonstration services, will remain candidates for another 12 months of demonstration services during the grant period. The same eligibility criteria will apply to the second transition. A thorough review of the original transition including the transition assessment and care plan will be conducted to mitigate any obstacles for a second transition.

To prevent readmission to an institution, case managers will perform a re-assessment of the MFP participant annually and any time there is a significant change in status. A review and update to the care plan may be necessary at any time but will be required on an annual basis.

If the MFP participant must be re-institutionalized for more than thirty (30) consecutive days, the case manager will contact the Transition Coordinator who will evaluate for

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continued MFP eligibility. If the MFP participant is still eligible to participate, the Transition Coordinator will work with the case manager to create an updated care plan if needed. If after three (3) incidences/occurrences of re-institutionalization of thirty (30) consecutive days or longer, the individuals will no longer be considered for re-entry into the MFP project.

Ultimately, the decision to return to the community remains with the individual and/or his/her representative, regardless of MFP eligibility and participation.

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h. The State's procedures and processes to ensure those participants, and their families will have the requisite information to make informed choices about supports and services. The description shall address:

Deleted: Individuals who want to relocate and who meet the eligibility criteria will be encouraged to return to the community.

i. How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.

ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished

The MFP Project Director will be responsible for training DAIL staff, in conjunction with the Community Development Specialists. Training will occur over a period of four to six weeks. MFP staff will then perform the necessary training and community outreach to MFP participants and the general population.

During the transition planning sessions, the Transition Coordinator will provide each participant with a Choices for Care Participant Handbook describing their rights and responsibilities, as well

as the state's protections from abuse, neglect, and exploitation. The handbook will also be updated to include information on how participants and/or their representative can notify the appropriate authorities or entities when the participant may have experienced abuse, neglect, or exploitation. (Appendix C contains a copy of the current Handbook.)

Transition Coordinators will train participants on how complaints of abuse, neglect and exploitation are investigated by DAILE and then referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Program Integrity Unit. Information pertaining to abuse and neglect will also be disseminated by the participant's assigned case manager once they are living in the community setting. The case manager will review the information provided in the Choices for Care Participant Handbook as well as reinforce the general MFP training that was performed initially by the Transition Coordinator before the individual transitioned.

The Transition Coordinator will monitor the participant in the community weekly during the first six months (with at least one face-to-face visit per month) and collaborate with the assigned case manager. During this "on-boarding" period, training and education about MFP will be reinforced and individual questions answered. After the first six months, the assigned case manager will have monthly contact with the participant during which time training and information will be reviewed and reinforced.

B.2 Informed Consent and Guardianship

a. Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

All participants (or as appropriate, family members or guardians) will be required to sign a consent form to enroll in Vermont's MFP demonstration. By signing the consent form, participants acknowledge that they have freely chosen to participate, are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and thereafter, are aware of the waiver requirements and are informed of their rights and responsibilities as a participant in the demonstration.

Procedures to Obtain Consent

DAIL will provide interested parties with an "MFP Transition Packet," which includes a (1) cover letter; (2) MFP application (referral) form with information about who to call; (3) Informed Consent form; (4) Brochure and Fact Sheet; (5) Eligibility Information; (6) Choices For Care Participant Handbook; and (7) Qualified Residence Form. Transition Coordinators will provide the packets in person whenever possible. If the applicant requests that the packet be mailed, the Transition Coordinator will make a follow-up contact after informational materials are sent by DAIL to schedule a transition planning meeting.

A Transition Coordinator will thoroughly review the contents of the packet during the onsite transition meeting he/she has with a potential applicant and/or guardian and prior to asking applicants or guardians to sign the consent form. The meeting with the Transition Coordinator will provide an opportunity for specific dialogue focused on all aspects of the MFP process, including pre- and post-transition activities. The participant and/or guardian will also receive a clear explanation about their rights and responsibilities as well as procedures for incident reporting and complaints. The Transition Coordinator will address any questions or concerns about the project during this time.

Nursing facility residents who are interested in moving to the community and who do not require a guardian or representative will then sign the MFP Consent Form and participate in the MFP intake process. A draft of the MFP Consent Form is located in Appendix D.

In the event the participant requires a representative to provide informed consent for the MFP demonstration, the consent for participation may be provided by the participant's family member, caregiver, a health care agent named in a health care power of attorney, an attorney-in-fact named in a durable power of attorney, or the legal representative or surrogate decision-maker who has responsibility for the individual's living arrangement. In situations where there is a legal representative or surrogate decision maker, the Transition Coordinator will review legal documentation to ensure the individual possesses the authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

b. Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.

Private Guardianship

In Vermont, a court may enter a judgment pursuant to subsection 3068(f) of Title 14, Chapter 11 of the Vermont Statutes and appoint a guardian if it determines that the respondent is unable to manage, without the supervision of a guardian, any or all aspects of his or her personal care and financial affairs. The court must grant powers to the guardian in the least restrictive manner appropriate to the circumstances of the respondent and consistent with any advance directive. Guardianship powers may be ordered only to the extent required by the respondent's actual mental and adaptive limitations. The court must specify the powers the guardian shall have and may further restrict each power so as to preserve the respondent's authority to make decisions commensurate with respondent's ability to do so.

The guardian must maintain close contact with the person under guardianship and encourage maximum self-reliance on the part of the person under guardianship. The guardian must always serve the interests of the person under guardianship and must bring any potential conflicts of interest to the attention of the court.

In addition to the powers vested in the guardian by the court pursuant to section 3069 of Title 14, the court may order the guardian to assure that the person under guardianship receives those benefits and services to which he or she is lawfully entitled and needs to maximize his or her opportunity for social and financial independence. Those benefits and services include, but are not limited to:

- Residential services for a person under guardianship who lacks adequate housing;
- Nutrition services;
- Medical and dental services, including home health care; and
- Therapeutic and Habilitative services, adult education, vocational rehabilitation or other appropriate services.

Competent individuals of at least 18 years of age may serve as guardians. In appointing an individual to serve as guardian, the court shall take into consideration:

- The nomination of a guardian in an advance directive or in a will;
- Any current or past expressed preferences of the respondent;
- The geographic location of the proposed guardian;
- The relationship of the proposed guardian and the respondent;
- The ability of the proposed guardian to carry out the powers and duties of the guardianship;
- The willingness and ability of the proposed guardian to communicate with the respondent and to respect the respondent's choices and preferences;

- Potential financial conflicts of interest between the respondent and the proposed guardian, and any conflicts that may arise if the proposed guardian is an employee of a boarding home, residential care home, assisted living residence, nursing home, group home, developmental home, correctional facility, psychiatric unit at a designated hospital, or other similar facility in which the respondent resides or is receiving care; and
- Results of any background checks.

Public Guardianship

An Office of Public Guardian is established within DAIL for the purpose of making guardianship services available to mentally disabled persons 60 years of age or older for whom the probate court is unable to appoint a guardian from the private sector. In addition to the powers and duties of guardians set forth in the statute, the Office of Public Guardian through its designees must:

- Be considered a person interested in the welfare of the ward for purposes of filing a motion for termination or modification of guardianship.
- Visit the facility in which the ward is to be placed if it is proposed that the ward be placed outside his or her home.
- Monitor the ward and the ward's care and progress on a continuing basis. Monitoring must, at a minimum, consist of quarterly personal contact with the ward. The Office of Public Guardian must maintain a written record of each visit with a ward. A copy of this record must be filed with the probate division of the superior court as part of the required annual report. The office, through its designees, must maintain periodic

contact with all individuals and agencies, public or private, providing care or related services to the ward.

When an MFP participant has a guardian, the Transition Coordinator will verify the guardian's appointment by either viewing the guardianship papers or by contacting the probate court directly. As is the case today for Choices for Care, the Transition Coordinator will require a guardian's signature on the all forms and documents pertaining to the program.

Guardians will be invited to all transition meetings and other relevant encounters with the participant. Their maximum participation will be encouraged throughout the process.

It will be the Transition Coordinator's responsibility to educate the guardian about Vermont's MFP demonstration and the transition and post transition processes. The guardian must report recent visits or interactions to the Transition Coordinator at the time the consent is signed and on a quarterly basis. To the extent documentation of such contacts are available through the Area Agencies on Aging or other public surrogate organizations, the Transition Coordinator will request information on recent visits and file this in the participant's case record.

Private guardians will be encouraged to visit individuals for whom they have been awarded guardianship and to provide information on the frequency of their visits to the Transition Coordinator. A minimum of one visit between the guardian and the participant must be

documented within the six-month period prior to transition and then every six months thereafter.

The Transition Coordinator will review and document as to whether or not guardians have recent knowledge of a participant's welfare if they are making decisions on behalf of the participant. Such documentation will be in the form of case notes, care planning meetings, social services notes, and telephone records reflecting active participation in decision making. If the Transition Coordinator has reason to believe that a private guardian is not acting in the best interests of the participant, he/she will report such information to Adult Protective Services within DAIL's Division of Licensing and Protection.

B.3 Outreach/Marketing/Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: The OP Draft required in this application does not require a State to submit marketing materials at this time. All marketing materials will be submitted during the final approval process for the Operational Protocol.

Please provide:

a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);

Vermont's Choices for Care program provides Long-Term Care Services for frail elders and adult Vermonters with physical disabilities. Created in 2005 as an 1115 waiver, the program is already well established and offers long-term services and support systems throughout the state. Because of the success and awareness of this program, participation in the MFP demonstration for enrollees, nursing facilities, state staff and other key stakeholders is expected to be high.

To assure the successful implementation of Vermont's MFP demonstration, generic outreach and marketing materials will be developed by the Project Director within 30-days after their hire. Materials will be used across a wide range of audiences and locations throughout the state. The materials will be modified to meet the needs of the different audiences, such as nursing facilities, enrollees, family members, and advocacy organizations, while at the same time also contain some general facts and information. The primary goal for Vermont's marketing and outreach campaign will be to ensure the MFP demonstration is easily recognized, understood and accessible to its target audiences.

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Enrollees

Participants in Vermont's MFP demonstration will be those who have expressed an interest in transitioning and who wish to live and receive supports and services in the community of their choosing. Additionally, there will be family members, caregivers, guardians, and advocates of people who reside in nursing homes who will need to be educated about the program. To that end, the following is a preliminary list of the information that will be communicated:

- The existence of Vermont's MFP demonstration and its objectives;
- The program opportunities afforded through MFP, such as to move into a community setting, to become more independent and to access an array of community-based services;
- Eligibility requirements;
- Benefits and services (including self-direction);
- How to participate;
- The transition process (pre and post-transition);
- Your rights and responsibilities; and
- Who to contact to learn more about how to get started

Participating Providers

Providers in Vermont's MFP demonstration include medical directors, administrators, discharge planners and social workers employed in nursing facilities as well as well as the array of home and community-based service providers. In addition to what is communicated to enrollees, the state will furnish the following information to providers:

- How people can participate in Vermont’s MFP demonstration;
- Identification of potential participants;
- How to enroll in the program;
- When and how to receive training about the program;
- Their role in helping people participate in the program; and
- Program implementation and next steps

State Outreach/Education/Intake Staff

“State staff” refers to DAIL employees and their contractors who will be involved in the MFP demonstration, as well as staff at other Vermont state and county-level agencies interacting with demonstration participants or otherwise supporting the program. The following topics, in addition to the above information for enrollees and providers, will be covered for this audience:

- Upcoming training opportunities;
- Overview of the initiative and their roles;
- How they can make the program a success;
- Disparities in the community to be addressed (i.e. housing, supports);
- Program sustainability;
- Program statistics and data collection;
- Program resources;
- Vermont’s community service capacity; and
- Who to contact for programmatic and other questions

b. Types of media to be used;

In order to raise awareness about the MFP demonstration, Vermont will use multiple media and communication tools to reach the many stakeholders involved, including at least the methods described below.

Enrollees/Families/Caregivers/Guardians/Advocates/General Community

These individuals will receive information on Vermont's MFP demonstration via a brochure and factsheet that features a description of the initiative, eligibility requirements, benefits and services, how to participate and how to obtain additional information. DAIL will include a senior helpline phone number to call for more information. The phone number will immediately direct callers to their local Area Agency on Aging based on the caller's location. Callers also will be able to inquire about the program by calling Vermont's 211 line and any of the ADRC partner agencies, which includes the Area Agencies on Aging, VCIL and the Brain Injury Association of Vermont.

DAIL also will use mass media, including advertisements and press releases in local newspapers, relevant newsletters and publications throughout the state. The department also will broadcast messages on television and radio to announce the roll-out of the demonstration as well as highlight how individuals who are aged or have disabilities have transitioned from a nursing facility and live successfully in their communities.

DAIL staff (or the Area Agency on Aging) will mail an MFP participant packet to interested individuals when they call for more information. The packet will include a (1) cover letter; (2) MFP application (referral) form with information about who to call; (3) MFP Informed Consent form; (4) Brochure and Fact Sheet; (5) Eligibility Information; (6) Choices For Care Participant Handbook; and (7) Qualified Residence Form. Transition Coordinators will also perform in-person visits to nursing facilities to discuss the program with residents or potential candidates as well as provide some of the written materials previously mentioned.

DAIL will have a dedicated page within the Choices for Care website designed to offer a information about the MFP demonstration to an array of audiences, including potential participants and their families, providers and other program stakeholders. Information will be made available in alternative formats, such as CDs, tapes, video upon request.

Participating Providers

DAIL will use many of the outreach tools detailed above for participating providers. Additionally, letters will be provided to administrators of nursing facilities across the state for which individuals will be transitioning. Letters will explain the project as well as what to expect for the period of the demonstration. Another series of letters will be disseminated to home- and community-based service providers to inform them about the program and to provide information about upcoming community forums and training sessions. DAIL will also host community forums to explain the programs to providers as well as perform a number of onsite

visits to nursing facilities and community-based providers. Choices for Care Waiver Teams will be an additional forum to advance this project to the local providers and case managers.

State Outreach/Education/Intake Staff

State staff and advocacy groups will receive information via DAIL's website, fact sheets, brochures and training sessions. Similar to the provider outreach initiatives, DAIL will host community forums to explain the program and how to participate.

c. Specific geographical areas to be targeted;

Since the MFP demonstration is being implemented statewide, the area to be targeted will be the entire state of Vermont.

d. Locations where such information will be disseminated;

Information about the program will be disseminated to multiple audiences across the state in numerous locations, including but not limited to: nursing facilities; provider offices; community-based providers; county departments; local advocacy organizations, including the Center for Independent Living; professional associations; state agencies; non-profit organizations; Area Agencies on Aging/ADRCs; local libraries; and other community locations places (e.g., stores and recreation centers).

e. Staff training plans, plans for State forums or seminars to educate the public;

Training sessions relevant to MFP will be offered to health care providers and professionals working with this population. The groups to be trained by the MFP Project Director and Community Development Specialists are discussed below.

Nursing Facilities

DAIL will direct training efforts to nursing facility social workers and discharge planners, covering MFP eligibility requirements and the program referral process. Onsite training sessions will take place at designated nursing facilities across the state.

Transition Coordinators, Case Managers and other MFP Staff

Transition Coordinators, case managers and all other MFP staff will receive specific training targeted to their role so they can in turn train demonstration participants. The training will include:

- Overview of the MFP demonstration;
- Eligibility requirements;
- Benefits and services;
- Vermont MFP Operating Protocol;
- Self-direction;
- Quality Management;
- MFP Referral and Intake Process;
- MFP Assessment, Care Planning and Case Management;

- MFP Transition Process;
- MFP providers and resources;
- MFP Policies and procedures, including informed consent and back-up planning;
- Participant rights and responsibilities;
- Documentation and its importance;
- Agency coordination;
- Safety in the Home; and
- Special Conditions, including behavioral health and dementia

Training will occur over a four to six week period and include both classroom and field-based activities. The MFP Project Director or designee will provide follow-up training as necessary, which, in the case of Transition Coordinators, could include shadowing the individual for a period of time until satisfied they can work independently.

Providers of MFP Services

Vermont has numerous home and community-based service providers and advocacy groups, including home health agencies. Those participating in MFP will be required to attend training on a semi-annual basis. The content of the training will be similar to the training for Transition Coordinators. Training sessions will be offered onsite at locations throughout the state.

State Forums to Educate the Public

State forums will be offered annually beginning in the spring of 2011 and will focus on educating participants, advocates, state, county and local agencies and the general public about Vermont's MFP demonstration. Specific topical training will be offered to meet the needs of particular groups and will be held at times and locations where the demand exists. DAIL also will assemble ad-hoc workgroups/taskforces as the need arises to address project challenges and to address solutions. (See section 4.B for additional information on the demonstration's ad hoc stakeholder work group.)

f. The availability of bilingual materials/interpretation services and services for individuals with special needs;

Vermont accommodates individuals with special needs and those with Limited English Proficiency (LEP) under the existing waiver program and will make such services available at no cost to MFP demonstration participants. In-person interpreter services for all needed languages are provided through the Association of Africans Living in Vermont. DAIL also will provide TDD services for hearing impaired individuals. Outreach and educational materials will be made available, upon request, in alternative formats, such as Braille, large font letters, audiotape, and non-English languages.

g. A description of how eligible individuals will be informed of cost sharing responsibilities.

Vermont's MFP participants will not be required to pay a cost-share deductible for the program aside from the standard share of cost they are paying today.

B.4 Stakeholder Involvement

Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant. Please include:

a. A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.

Vermont has a longstanding commitment to the inclusion of private and public stakeholders in the design, development and evaluation of new initiatives for its Global Commitment to Health and Choices for Care waiver programs. Prior to making the decision to submit an application under the Money Follows the Person demonstration, the state consulted with a broad range of stakeholders through a series of formal public meetings and in-depth interviews.

Exhibit 8 below identifies the private and public stakeholder groups consulted during the development of the application. These same groups will continue to assist in the implementation of the demonstration, if a grant is awarded, through the mechanisms described further below.

Exhibit 8 - Public and Private Stakeholders

Private Stakeholders	Public Stakeholders
<ul style="list-style-type: none"> ▪ Consumers (multiple) ▪ Community of Vermont Elders ▪ Vermont Center for Independent Living ▪ HomeShare Vermont ▪ Vermont Association of Area Agencies on Aging ▪ Visiting Nurse Association of Chittenden/Grand Isle Counties ▪ Vermont Assembly of Home Health & Hospice Agencies ▪ Individual HCBS providers (multiple) ▪ Vermont Health Care Association ▪ Vermont nursing facilities (multiple) ▪ Vermont Designated Agencies (community mental health centers) 	<ul style="list-style-type: none"> ▪ Office of Public Guardian ▪ Department of Vermont Health Access ▪ Department of Health ▪ Department of Mental Health ▪ Department of Disabilities, Aging and Independent Living (DAIL) <ul style="list-style-type: none"> – Division of Disability and Aging Services (DDAS) – Division of Licensing & Protection – DDAS Long Term Care Clinical Coordinators (multiple)

The meetings and interviews explored the following topics:

- What types of nursing facility residents would benefit from participation in the demonstration?
- How should stakeholders assist in conducting outreach and identifying eligible residents for the demonstration if a grant is awarded?
- What barriers to transition should the demonstration seek to address, in terms of transition coordination activities, housing alternatives and ongoing home- and community-based services?

- How adequate is HCBS capacity and what gaps must be addressed to facilitate transition of eligible nursing facility residents?
- How should the demonstration be integrated into the broader Choices for Care waiver program?
- What would be the potential impact on the broader Choices for Care system, in terms of expanding options for all long-term care beneficiaries, including new entrants into the program still residing in the community?
- Should the state proceed with submitting an application?

Stakeholder recommendations have had a significant impact on the design of the proposed demonstration, including with respect to defining target populations and the support services and housing alternatives necessary to overcome barriers to transition. The inclusiveness of the process has resulted in broad support for the application, as reflected in the letters of endorsement received from consumer, provider and public stakeholder representatives. The letters are included in Appendix E of the application.

The state will collaborate with stakeholders on the development, implementation and operation of the demonstration through a formal structure created for such consultation: the DAIL Advisory Board. As required by statute, a majority of the Board members are older persons and persons with disabilities, selected for their familiarity with and interest in programs and issues affecting the interests of older persons or persons with disabilities.

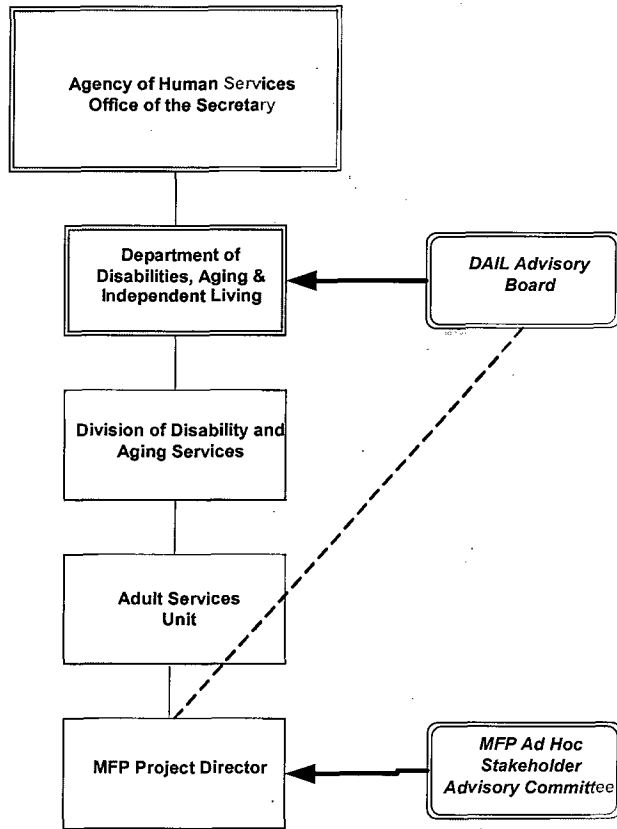
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Aging and Independent Living

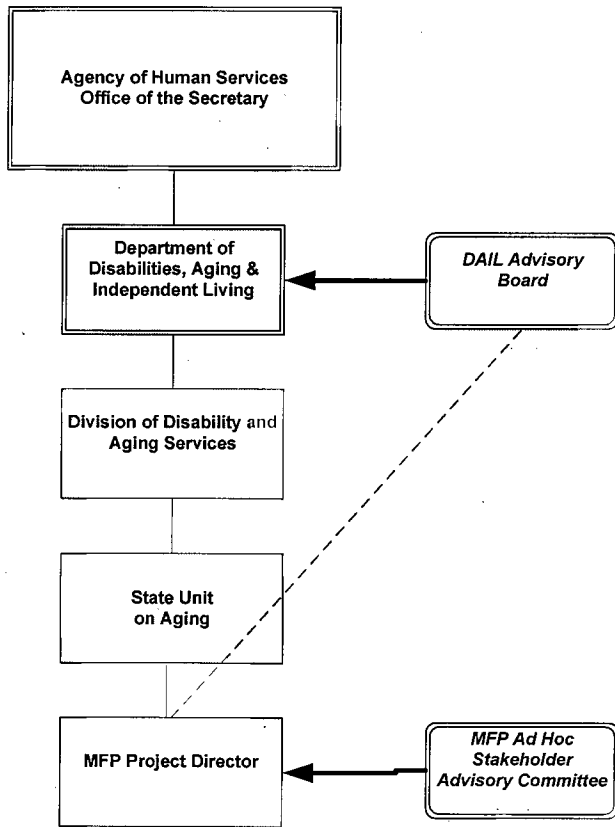
The DAIL Advisory Board meets monthly and serves as an active forum for discussion of new state initiatives and existing programs. The MFP Project Director will provide regular updates to the Board during implementation of the demonstration and consult on strategies for addressing and resolving challenges that arise.

In addition to the DAIL Advisory Board, the MFP Project Director also will collaborate with an ad hoc committee of consumer, provider and public stakeholders originally convened to explore options for expanding placement alternatives under Choices for Care. The committee, which has been actively engaged in designing an Adult Family Care benefit, was consulted on the design of the demonstration from its earliest stages through submission of the application. Committee members will continue to advise the MFP Project Director and other DAIL staff on the implementation of the demonstration, if a grant is awarded.

Exhibit 9 below illustrates the two formal channels through which stakeholder views will be heard and their relationship to the organizational structure of the grant.

Exhibit 9 - Formal Stakeholder Structure





b. A brief description of how consumers' will be involved in the demonstration.

As discussed above, Choices for Care consumers participated in designing the demonstration model through their involvement in both the DAIL Advisory Board and Ad Hoc Stakeholder Advisory Committee. Consumer representatives were forceful advocates for creation of the new housing alternative (Adult Family Care) and one-time transition payment proposed for the demonstration population. They also offered important insights into the other support services that will be necessary to facilitate the successful transition of long time nursing facility residents back into the community.

Although not consumers themselves, representatives from the Vermont Office of Public Guardian (OPG) played, and will continue to play a vital role in the demonstration. During the design phase, OPG representatives assisted in researching the number of potential eligible nursing facility residents and consulted on the barriers to transition confronting aged and disabled persons under their guardianship. OPG representatives will continue to be actively engaged during the life of the demonstration in identifying, and facilitating the transition of, residents under public guardianship.

Other consumer representatives will continue to be involved in the demonstration through their participation on the two committees, and through less formal methods. As residents of a small state, Vermont citizens also regularly have the opportunity to meet and correspond informally with public officials. Their opinions are valued and treated with respect, regardless of the venue in which they are provided.

c. A brief description of community and institutional providers' involvement in the demonstration.

The Vermont Health Care Association and its member nursing facilities have a collaborative relationship with the state and are active partners in the existing Choices for Care waiver. The industry worked closely with the state in the summer and fall of 2010 to conduct an initial feasibility analysis for the demonstration. The analysis included onsite visits to eleven facilities selected to be representative of the 44 Medicaid-participating facilities across the state.

Clinicians working on behalf of DAIL met with administrators and social service/discharge planning directors at the eleven facilities to review their current resident population and determine the number who would qualify under the demonstration. Findings were used, in combination with data from other stakeholders (e.g., Office of Public Guardian) to estimate the total number of demonstration-eligible residents in the state.

The nursing home representatives also conferred with DAIL on the barriers to transition facing demonstration-eligible residents in their facilities. These included the need for one-time transition funding, new housing options and accessible community mental health services. The demonstration design ultimately addressed all of these barriers through a combination of new benefits, proposed placement options and strategies for ensuring access to behavioral health services through the state's Designated Agency (CMHC) system.

Vermont's community providers also participated in the demonstration design through their involvement in the two committees and through regular consultation with DAIL staff. They have been particularly active in assisting with creation of the proposed Adult Family Care housing option, including with respect to provider training, and safety and licensing.

Choices for Care case managers and community providers will continue to play an integral role under the demonstration, as the front line organizations and individuals responsible for ensuring the safety and quality-of-life of demonstration participants. This will include management of transition payments, provision of intensive case management following discharge and delivery of home- and community-based services in strict accordance with member care plans.

d. A description of the consumers' and community and institutional providers' roles and responsibilities throughout the demonstration.

As discussed above, consumers, consumer representatives and institutional providers will participate in oversight of the MFP demonstration through their participation in the Advisory Board and ad hoc committee.

e. The operational activities in which the consumers and community and institutional providers are involved.

Consumers will make the fundamental decision as to where they will reside and those who elect to self-direct their care will become employers within the demonstration.

Nursing Facilities will be responsible for identifying eligible residents through responses to Section Q of the MDS 3.0 and notifying MFP Transition Coordinators to begin the discharge planning process. They will be part of the transition team with shared responsibility for ensuring residents return to the community in a safe fashion.

Community providers will serve as the core network for provision of services under the demonstration and will be active participants in the stakeholder process through their involvement in the ad hoc committee.

B.5 Benefits and Services

a. Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (1915 a, b, c or combination waiver, 1115 demonstration, Medicaid State Plan, 1915i and 1915j, etc.). For all HCBS demonstration services and supplemental demonstration services State must detail the plan for providers or the network used to deliver these services. Some demonstration services may be added to existing 1915 waivers during the MFP demonstration period, but the services that are not added and the supplemental services not paid for through Medicaid will end at the 365th day for each individual participant.

Service Delivery and Financing Model

Vermont MFP demonstration participants will be enrolled in the state's Section 1115 Choices for Care waiver. A separate demonstration waiver will not be created for the ongoing services provided through the MFP project. Choices for Care is a managed care waiver, although Vermont does not utilize managed care organizations (MCOs) to administer the waiver services. Instead, payment is made using a fee-for-service model that will continue to be used for the MFP demonstration.

At the termination of the demonstration period, individuals will continue to receive Qualified HCBS through Choices for Care as long as they meet the eligibility requirements of the program. Pursuant to terms and conditions of the grant, MFP demonstration services will not be available after the 365-day demonstration period. Vermont is not proposing to offer any supplemental services as part of the MFP demonstration.

Providers or Network to Deliver Demonstration Services

Vermont will rely on its current network of Choices for Care providers to deliver services for the MFP demonstration including home health agencies, PACE, small residential care homes and assisted living residences. Vermont currently has eleven regional not-for-profit home health agencies and one statewide for-profit provider. Each of the not-for-profit agencies serves a defined geographic region on a non-competitive basis. This model has been in place in Vermont for many years, and has been shown to work best in an environment that is largely rural, and not conducive to competitively driven profit centers. Vermont's PACE provider also provides community based services in the Chittenden and Rutland county areas of the state. PACE provides all care and services with a monthly Medicare and Medicaid prospective payment. Other services will be provided by community-based entities, such as Area Agencies on Aging, Durable Medical Equipment vendors, home adaptation contractors, adult day centers, and individual attendants hired and supervised by Demonstration enrollees.

Deleted: In Vermont, many of these services are provided by home health agencies.

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Deleted: small residential care homes and assisted living residences,

Vermont will offer a one-time transition payment to participants in the amount of \$2,500. These transition payments will be controlled and monitored by the Transition Coordinator assigned to the participant. Since this will be a benefit in the form of a payment and not an actual service, DAIL will not require a network of providers for this demonstration service option.

*b. List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). **Do not include acute care service or institutional services that will be paid for through the regular Medicaid program.** In a chart, divide the service list(s) into Qualified Home and Community-Based*

Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

Service Package for MFP Participants

Qualified HCBS

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The same HCBS system that is currently in place under the Choices for Care program will be in effect for the MFP demonstration program. This includes both fee-for-service providers, individuals acting under the consumer/surrogate direct options, Enhanced Residential Care services and PACE. Claims from agency providers will be submitted and reimbursed by the state's Fiscal Intermediary (currently Hewlett Packard) in accordance with requirements and fee schedules in effect for the program. Claims generated by services provided for consumer or surrogate directed care will be processed by the state's Fiscal/Employer Agent who will, in turn submit these claims to the Medicaid Fiscal Intermediary. Individual providers or groups of providers will not be at-risk financially for the cost of care for any individual enrollee or group of enrollees.

Deleted: Under Choices for Care, fee-for-service providers and individuals acting under the consumer/surrogate directed options provide the home- and community-based services authorized under the enrollee's comprehensive care plan.

Deleted: capitated or

Vermont will add one additional Qualified HCB service as part of the MFP demonstration: Adult Family Care. An Adult Family Care home is a private, single-family residence in which the provider cannot be related to the resident. Adult Family Care homes can provide in-home services to waiver participants, including personal care, companion care, medication oversight,

and transportation. The services are provided in a home-like environment that includes a private bedroom, a private or semi-private bathroom, home-cooked meals, a common living area, and assistance with activities of daily living. Residential Care Homes that house three or four residents are subject to licensure by DAIL as a residential care facility. Adult Family Care Homes, which will house one or two residents, will be subject to safety inspection and continuing oversight by DAIL staff or case management staff from one of the Choices for Care case management agencies.

Demonstration Services

Vermont will introduce a one-time transition payment for individuals who are moving from a nursing facility to a community setting or another living arrangement where the person is directly responsible for his/her own living expenses. The one-time transition payment is furnished only to the extent that the person is unable to meet such expenses, or when the support cannot be obtained from other sources. Transition services do not include any services not associated with household start-up. The Transition Coordinator assigned to the participant will monitor the use of the funds so that the funds are used as intended and only in the amount needed.

The monetary limit for transition services is \$2,500. Transition services are only available once in the lifetime of waiver enrollment, and must be accessed within 90 days of the first day of transition from the nursing facility. Sound judgment will be used when approving services to

ensure purchases are modest and reasonable. Funds cannot be used to pay existing bills or past due balances.

HCBS Supplemental Services

Vermont does not intend to offer supplemental services.

Exhibit 10 below summarizes the MFP benefit package by service type.

Exhibit 10 – Vermont MFP Benefits

Service Options	Qualified HCBS	HCBS Demonstration	Supplemental Demonstration
Personal Care Services (including homemaker tasks)	X		
Respite Care	X		
Companion Services	X		
Adult Day Services	X		
Personal Emergency Response Systems	X		
Assistive Devices	X		
Home Modifications	X		
Enhanced Residential Care	X		
Case Management Services	X		
Other living arrangements*	X		
One-time transition payment		X	
Case Management**	X		
PACE	X		
Adult Family Care	X (new)		

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Comment [m5]: By definition, Enhanced Residential Care services pays for care in both Level III residential care and assisted living residences.

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Comment [m6]: Homemaker is not a separate service. Homemaker tasks are included in the personal care service.

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* *Optional Services – Availability dependent on funding, subject to overall budget neutrality limitations.*
 ** *Vermont has a review process under Choices for Care whereby individuals who need more intensive case management (i.e., more case management contact time) can be authorized*

to receive additional minutes. MFP participants will be eligible to receive additional case management time through this process.

B.6 Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

a. A description of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;

MFP demonstration participants will be utilizing Vermont's existing waiver program, Choices for Care, for the delivery of home and community-based services and supports. The current systems for consumer supports that are approved and in place for Choices for Care will be used by MFP demonstration participants as well, both during the MFP demonstration and thereafter. Vermont has begun and will continue to develop the necessary back-up systems and supports as part of this demonstration program to ensure the necessary infrastructure is in place.

As part of this endeavor, and as discussed in B3. Outreach/Marketing/Education, DAIL will develop a transition packet for distribution to all potential participants. The packet will contain an array of educational materials outlining the services and supports provided through the MFP demonstration. The materials will include information on procedures for accessing needed assistance and supports, including 24-hour backup systems. Potential participants also will be provided with a "Just in Case" booklet to be used for personal emergency preparedness planning.

Each demonstration participant will be provided with a transition packet and training as well as transition planning services by a Transition Coordinator prior to moving from a nursing facility

into the community. The materials and services will ensure that participants have access to the assistance and support that will be available to them as part of the MFP demonstration.

An individualized care plan will be developed in collaboration with each MFP participant, the Transition Coordinator and the assigned case manager prior to transition into the community. The care plan will address the individual's needs as they relate to supports, services and emergency backup plans.

At the time the care plan is developed, the case manager will assist the individual in developing an emergency backup plan. This plan will identify at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. This could consist of both formal and informal providers, such as family, friends and neighbors who have agreed to support the participant on an emergency basis. It will also include a list of emergency contacts. Appendix F contains a copy of the Emergency Contacts and Backup Plan.

A copy of the care plan, backup plan and emergency contact list will be placed in a conspicuous location in the participant's home. The case manager will also maintain copies of these materials in their files. For additional information on risk assessment/mitigation, critical incident reporting systems, and 24-hour backup, please refer to the Quality section, B.8.

b. A description of any 24 hour backup systems accessible by demonstration participants including critical services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website). Include information for back-up systems including but not limited to:

i. Transportation

ii. Direct service workers;

iii. Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are made); and

iv. Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.

24 hour Backup Systems

For MFP participants, the first level of backup will be identified as part of their care plan (the backup plan) and include at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. The plan also will include a list of emergency contacts.

The second level of back-up will be the assigned case manager/case management agency. If the back-up provider on the care plan is not able to resolve the issues for the participant, the case manager or their agency will be contacted for assistance.

Case management agencies are required to offer 24-hour telephone access through an answering service or other means. However, as a further safety measure, DAIL plans to contract with Vermont 211 to provide 24 hour backup services for MFP participants.

Vermont 211 is a toll-free information and referral telephone service where trained call specialists provide information, problem solve and refer callers to government programs,

community-based organizations, support groups, and other local resources across the state.

Vermont 211 is available 24 hours a day, 7 days a week and offers live translation services for 170 languages. MFP participants can be transferred to 911, crisis services, Adult Protective Services and other agencies that can assist them. Call specialists are trained to assist callers with an array of services including, but not limited to, the following:

- Clothing and Thrift Shops
- Consumer Services
- Crisis Services
- Discrimination Assistance
- Domestic and Sexual Violence Services
- Education—GED Instruction, Computer Classes
- Employment Services
- Food Shelves and Nutrition Programs
- Health Care Services
- Alcohol and Drug Programs
- Housing—Homeless Prevention, Shelter, Tenants' Rights
- Independent Living Services
- Legal Assistance
- Mental Health Care and Counseling
- Mentoring
- Senior Information & Assistance
- Stop Smoking Programs

- Support Groups
- Transportation
- Utility Assistance

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The Project Director, with assistance from other MFP staff, will train VT-211 on all aspects of MFP as well as provide phone numbers to which callers can be referred or transferred. Training will occur before the first MFP participant is transitioned to the community. VT-211 will be required to document and track the receipt of calls and requests.

Call metrics will be tracked to monitor responsiveness and timeliness with respect to consumer calls as well as the number and type of participant requests for critical backup. All reports will be submitted to an MFP QM specialist on a monthly basis. The QM Specialist will analyze and track and trend this information in order to identify any improvements or modifications that need to be made for the program. For each MFP participant who requires emergency backup services, follow-up contact will be made to ensure the services are being provided.

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Transportation

Due to Vermont's rural nature, there is not one universal back-up system for transportation available to Choices for Care waiver participants. One of the first duties of the Community Development Specialist will be to develop a comprehensive list of transportation options available to MFP participants. The list will identify all transportation options by local area and

include contact phone numbers, the process for scheduling transportation and procedures for filing complaints.

This list will be made available to MFP participants, Transition Coordinators and case managers. The assigned case manager will provide all MFP participants with telephone numbers and contact names for transportation in their community or will place the call for the participant as necessary to arrange for transportation services.

Direct Service Workers

All HCBS providers under contract with the state are required to have protocols for replacing workers in the event that scheduled staff become unavailable. The 24 hour backup system will not supplant these contractual relationships already in place. However, the 24 hour backup system attendants will document reliability of the contracted provider and will assist with calls to the provider when necessary. Documentation will be reviewed by the QM Specialists.

The case manager will provide all MFP participants with his/her agency's telephone number as well as contact names and phone numbers for all of the service providers listed on in the care plan, in the event the participant experiences an interruption in services.

As is the case with Choices for Care today, all MFP participants will be required to have an emergency backup plan developed as part of their care plan. This includes participants who use traditional HCBS services as well as those who choose the self-direction option. An alternative

provider(s) will be identified as an emergency backup at the time that the initial plans are written with the case manager. For individuals who choose self- or surrogate-directed care, Vermont's Direct Care Worker Registry offers workers the option to state whether they are interested in doing on-call work. Consumers could use this option to develop a cadre of workers who are willing to cover their care on an as-needed basis.

Repair and Replacement of Durable Medical and other Equipment

During the development of the care plan, individuals in need of durable medical equipment (DME) and/or other equipment will be provided with contact information for contracted vendors in their area. Once a vendor(s) is selected, the case manager will provide MFP participants with the telephone numbers and contact names of who they should call when they experience a problem with durable medical equipment or other equipment. The MFP participant or the participant's case manager will communicate any equipment issues to contracted DME vendors so the necessary intervention can take place, such as the provision of loan equipment when repairs are made. DME providers are expected to maintain adequate and continuing service-support for Medicaid beneficiaries.

Access to Medical Care

The participant's case manager will assist with arranging services and ensuring that services are being delivered in accordance with the care plan frequency. The participant will be trained on how to schedule appointments and the assigned case manager will assist as necessary with

making initial appointment with HCBS and other service providers, such as the participant primary care physician for preventive and/or follow-up care.

The case manager will also assist the participant in dealing with problems or issues with appointments and how to get care issues resolved. The case manager will document phone calls with the participant and his/her providers in the member's case record and provide the necessary follow-up as part of the ongoing case management process.

In the event of an emergency situation with service delivery or with a provider, the case manager will report all occurrences to the designated QM Specialist so the necessary intervention can take place.

Supplemental Support Services

Vermont does not intend to offer supplemental support services.

c. A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.

MFP Participants have several options for registering complaints about services or any other aspect of their care. Participants will be encouraged to work initially with their agency providers around areas where care has not been satisfactory. Whether or not participants choose to do that, complaints may be registered directly with the DAIL, the participant's case manager, or the Division of Licensing and Protection or Vermont's Long Term Care Ombudsman Office.

The Division of Licensing and Protection (DLP) enforces federal and state statutes and regulations for providers of health care and investigates cases of alleged abuse, neglect and exploitation of vulnerable adults. To report abuse, neglect or exploitation of a vulnerable adult or to enter a complaint against a facility or agency that provides health care, MFP participants can call DLP's toll-free hotline or download a reporting form from their website.

Vermont Legal Aid is a non-profit law firm established in 1968 to provide free civil legal services to Vermonters who are low-income, older adults and those with disabilities. Vermont Legal Aid established Vermont's Long Term Care Ombudsman Program, which was created to protect the health, welfare and rights of people who live in long term care facilities, including nursing homes, residential care homes and assisted living residences. It also helps people who receive long term care services in their homes through Choices for Care.

The Ombudsman Program improves Vermont's long term care system through individual complaint resolution, education and administrative and legislative advocacy. Ombudsmen are available to receive and investigate complaints that consumers and their guardians have regarding services rendered under the Demonstration, providing third party oversight of the program. They also serve as consumer advocates.

MFP QM staff will be responsible for investigating and resolving complaints received by DAIL. Complaints will be logged on the day received and assigned to a QM Specialist for disposition.

The QM Specialist will acknowledge all complaints in writing within one business day. Written complaints will receive a response within seven days.

The QM Specialist will prioritize complaints based on severity and work for their expeditious resolution. If a proposed resolution is not satisfactory to the participant, he or she will be referred to the MFP Project Director for further remediation. The final resolution will be provided to the participant in writing and will include a recitation of their right to file a request for a fair hearing before the Commissioner of DAIL.

All steps in the complaint resolution process will be recorded on the log. The logs will be reviewed as part of the demonstration's quality assurance activities.

A description of the complaint process will be drafted and included in the Choices for Care Participant Handbook provided to MFP participants. DAIL will use the complaint process as a training tool for all MFP staff to ensure all members of the Unit understand the importance of timely complaint resolution and the steps in place to ensure this occurs.

B.7 Self-Direction

Sub-Appendix I is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form will be made available to applicants.

Appendix G contains a copy of "Sub-Appendix I Self-Direction Submittal Form", as required by application instructions.

CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval. In addition to completing Appendix A, please respond to the following:

a. Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.

Vermont Self-Direction Background

As noted previously, the Choices for Care program offers three options to individuals who wish to self-direct their services and supports and are able to manage the employer tasks and responsibilities: consumer directed, surrogate directed, or the Flexible Choices Program. In the home-based setting, Choices for Care offers three services that may be directed by the individual (consumer-directed) or a surrogate employer: personal care; respite care and companion services. MFP demonstration participants will be afforded the same options to self-direct their services as other enrollees in Choices for Care. This includes an "Employer Certification" process conducted by the participants case manager or consultant to assure the participant or their surrogate is capable of managing all required employer tasks and responsibilities. They also will follow the same process when electing to terminate self-direction in favor of an alternative service delivery method.

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Participants in the Flexible Choices Program are assigned to a consultant who acts as an advisor to provide assistance with all aspects of the program. The consultants will have primary responsibility for facilitating termination of self-direction.

When a participant expresses a desire to terminate self-direction and selects an alternative service delivery method, the consultant or case manager will review the steps for giving notice to employees and transitioning to other service providers. The notice period (typically two weeks) will provide the consultant or case manager the necessary time to arrange for updating the care plan, notifying the state and initiating the replacement services. If the participant is leaving Flexible Choices, this will include transferring them from the consultant to a case manager in accordance with existing procedures.

A copy of the revised care plan will be given to the participant upon its completion. The consultant or case manager, through contact with service providers and follow-up calls to the participant, will assure that no interruption in services occurs. The participant will be monitored on a daily basis during the transition, through a combination of phone calls and in-person visits.

b. Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition

The state will involuntarily terminate individuals from consumer direction, surrogate direction or the Flexible Choices program for a variety of circumstances, including but not limited to: 1) the participant is no longer eligible for Choices for Care; 2) the participant or surrogate is not

able to manage the requirements of being an “employer” or the requirements of the Flexible Choices Program; 3) the participant or surrogate commits fraud or otherwise inappropriately uses their resources; 4) the participant’s health, safety or welfare is at risk for any reason; or 5) the participant dies.

If the reason for involuntary termination has to do with a suspected change in cognition or inability to handle the program responsibilities, the consultant or case manager, prior to involuntary termination from either of the three self-direction options, will assess the member’s cognitive ability and ability to communicate effectively using either the Employer Certification Form for consumer or surrogate direction. The final determination will be made by the case manager or consultant.

Once a decision is made to involuntarily terminate an individual from self-direction, the Flexible Choices consultant or Choices for Care case manager plans and implements the return of the participant to provider-managed services, if they are still eligible for Choices for Care.

Participants are re-assessed for their level of service needs and the care plan is updated to include the amount and type of provider-managed services required. The care plan is then reviewed with the participant and/or surrogate.

The case manager arranges all services in a timely manner so there is no gap or delay in service delivery. During this transition period, the case manager will assure that all services are delivered by remaining in close contact with both the participant and the provider agencies.

The participant’s health and welfare will be monitored through phone calls, in-person visits to the participant, running late or missed visit reports, and re-assessing the participant as

necessary. Any suspected cases of abuse, neglect, exploitation are reported to Adult Protective Services and DAIL's QM Department via the Critical Incident Reporting System procedures.

c. Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

Vermont's goal is to promote understanding and awareness of self-direction for all MFP demonstration participants. Transition Coordinators will address this option during the assessment process in the nursing facility.

Vermont's goal is to have 25 unduplicated participants in self-direction by year five of the demonstration. This would represent one-third of the unduplicated participant count of 75 projected for year five.

B.8 Quality

Provide a description of the State's quality Improvement system (QI S) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 365 day demonstration period. Regardless of the financing and/or service delivery structure proposed under the demonstration, states must demonstrate how services during the 365 day transition period will:

- *be utilized to inform the CMS evaluation of the state's MFP demonstration; and*
- *Meet or exceed the guidance for a QIS set forth in version 3.5 of the 1915(c) HCBS waiver application.*

Please follow the guidelines set forth below for completion of this section of the OP:

Description of Vermont's Quality Improvement System

DAIL is responsible for oversight and evaluation of Vermont's Quality Improvement System (QIS). The QIS is developed in accordance with specific waiver assurances and the Home- and Community-Based Services (HCBS) Quality Framework.

DAIL has developed a comprehensive program for monitoring the level and quality of services provided to Choices for Care participants. The program is designed to ensure the highest possible level of quality of care and enrollee satisfaction. This same quality structure will be used for MFP participants both during the demonstration year as well as after the 365 day demonstration period.

DAIL is aware that the MFP demonstration grant occurs within the state's overarching Quality Management Plan (QMP) for the existing waiver programs within the department. The QMP will be modified to reflect unique features of the MFP demonstration, including the transition payment, Quality of Life Surveys and CMS evaluation, so the appropriate quality monitoring can

take place. Adult Family Care, a new Qualified HCBS benefit, also will be addressed through the QMP.

DAIL received a Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services to develop a comprehensive Quality Assurance and Quality Improvement Plan for Choices for Care. Over the past ten years, the Real Choice Systems Change Grants have sought to increase consumer and family participation and direction of their Medicaid services. Individuals who receive services, family members, service providers and DAIL staff formed the Quality Management Committee, which played a significant role in development of the QMP.

The primary objective for the QMP was to develop a quality management plan addressing all HCBS and to identify existing quality services and standards and quality management activities that are consistent with the CMS Framework. The second step was to identify and develop solutions for gaps within the current quality management system. As an outcome of this activity, new service standards that include quality in the design and delivery of services, a common set of quality indicators and language across waivers and a common set of quality indicators that incorporate the CMS Framework were developed to guide the delivery of service.

Since the completion of the Real Choices Grant, the QIS has been modified to focus more directly on specific programs. Modification of the current Quality Improvement System for Choices for Care has evolved into a program that follows the CMS Quality Framework, ensures

the quality of services delivered and ensures the health and safety of the participant. This same program will be in effect for MFP participants during the demonstration year and after the 365 day demonstration period.

The quality activities for the MFP program will be led by the two Quality Management Specialists assigned to the program. Their efforts will be supported by current quality staff assigned to the State Unit on Aging, which consists of a Manager and three Quality and Program Specialists. Reports of all quality related activities will be disseminated to DAIL's QI Committee.

The current QMP encompasses, or will encompass by the time the Vermont's MFP program is initiated, a range of activities that include, but are not limited to, the following:

- Review of functional assessments and level of care determinations
- Review and approval of all plans of care for demonstration enrollees
- Desk monitoring activities conducted by Long Term Care Clinical Coordinators (LTCCC), the individuals responsible for conducting level of care assessments and approving care plans for persons in home- and community-based settings
- Monitoring of services provided versus those included in the care plans
- On-site provider surveys
- On-site participant visits
- Ongoing case manager certification process
- Consumer satisfaction surveys

- Review and analysis of critical incidents
- Review and analysis of complaints
- Implementation of remediation activities

Consumer Satisfaction Survey - DAIL contracts with the University of Massachusetts for an annual consumer satisfaction survey based on a sample of recipients of home- and community-based care. DAIL will continue to administer this survey as part of the MFP demonstration in addition to the required CMS Quality of Life Surveys. To date survey results for Choices for Care show high levels of consumer satisfaction with the care received. While it is acknowledged that consumer satisfaction alone does not necessarily ensure that the care was of high quality, it is an important indicator.

Review and Approval of all Plans of Care and Certification of Case Managers - DAIL staff (LTCCC) review and approve all plans of care for Choices for Care participants and any subsequent changes to those plans. This ensures consistent approaches to care plan development and the allocation of resources. Additionally, all participants have a designated case manager. The case managers must have a face-to-face visit with their assigned enrollees at least once a month and more frequently if necessary.

Case managers are professionals who are certified after the receipt of training, the completion of required supervised practice hours and the demonstration of competent practice. Certification remains in effect unless revoked due to clear evidence that quality case

management services, consistent with DAIL Case Management Standards, are not being provided.

Tracking of Services Actually Provided - DAIL monitors the quantity of services provided to participants versus those listed on the care plan. This ensures that the oversight agency knows what portion of the services included on the care plan was actually provided. For a variety of reasons, it is unlikely that 100 percent of the services listed would be provided, but a significant portion should be delivered. In instances where an issue is identified by the state, DAIL staff will follow-up with the responsible agency. A system for electronically tracking and trending this information, by participant, is being developed.

Local Waiver Teams

Under the MFP demonstration, as with the larger Choices for Care system, local Waiver Teams will continue to provide significant oversight of the program. There are thirteen Waiver Teams throughout the state. These teams are comprised of case managers from the regional home health agencies and Area Agencies on Aging, as well as representatives of adult day centers, local Department for Children and Families/Economic Services Division offices, hospital discharge planners/social workers, residential care homes, assisted living residences and nursing facility social workers. Other providers, such as the Designated Agencies, join the teams as needed.

The teams meet monthly and review all active cases. Cases that involve outstanding issues are thoroughly discussed and alternative solutions or care approaches are reviewed. Under the demonstration, LTCCCs will continue to facilitate the Waiver Teams, and provide technical assistance and updates about any changes in policies and procedures. Transition Coordinators will participate on the teams as appropriate.

Oversight of Home Health Agencies/Residential Care Homes/Assisted Living Residences/Adult

Day Centers - Much of the care provided to MFP demonstration participants will be furnished by home health agencies located throughout the state. These agencies are subject to state and federal regulations and are regularly surveyed by the DAIL Division of Licensing and Protection. The inspections include a review of the quality assurance and quality management activities and functions of the agency. DAIL also provides direct oversight of the residential care homes/assisted living residences in the state through its licensing and surveying responsibilities. DAIL certifies all Adult Day Centers that receive state and/or federal funds are meeting the state standards.

Checks and Balances in the Provider System - Many MFP demonstration participants will receive services from multiple providers, including home health agencies, Area Agencies on Aging, adult day centers, respite service providers, transportation providers and individual attendants. The involvement of multiple provider organizations helps to ensure a series of checks and balances in the system because all of these providers are mandated by law to report

any actual or suspected abuse, neglect or exploitation. It also works to ensure that at least one provider will pick up on a situation that may be a precursor to future problems for the enrollee.

Other Quality Monitoring Activities - DAIL also conducts a variety of other monitoring activities to ensure quality of care. These include monitoring of grievances and appeals, nursing facility admission and re-admission rates to acute or long-term care facilities for participants, DAIL interviews with consumers, and changes in the functional status of enrollees based on their need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The expansion of the Long-Term Care Ombudsman program to include home-based care also adds an important new element to monitoring efforts. Additional monitoring activities are performed through the complaint line staffed by the DAIL Division of Licensing and Protection and through investigations by Adult Protective Service investigators.

a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

The state need not provide documentation of the quality management system already in place that will be utilized for the demonstration. But, rather provide assurances in the OP that:

- i. This system will be employed under the demonstration; and*
- ii. The items in section (C) below are addressed.*

In addition, the state should provide a brief narrative regarding how the existing waiver QIS is already or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.

The above section does not apply to the Vermont MFP demonstration.

b. If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), State Plan Amendment, or 1115) will address the items in section (c) below.

Vermont plans to integrate the MFP demonstration into its existing 1115 waiver program to serve individuals during and after the MFP transition year. Vermont will rely significantly on existing infrastructure to ensure that the MFP demonstration is operated in compliance with federal waiver assurances. DAAIL also will conduct additional oversight to assure the demonstration complies with federal assurances and other federal requirements.

Participants in the MFP demonstration will be served within the same case management, provider and oversight system as other Choices for Care enrollees. Vermont therefore can assure that the MFP demonstration will incorporate the same level of quality assurance and improvement activities required under the waiver program during the individual's transition and for the first year the individual is in the community.

As detailed in the description of Vermont's Quality Improvement System above, we have developed and will continue to enhance the existing QMP framework to ensure the quality of services delivered and the health and safety of participants in the MFP demonstration. Along those lines, the current delivery structure will address the waiver assurances articulated in version 3.5 of the 1915(c) waiver application as detailed in section (c) below upon implementation of the MFP demonstration.

c. The Quality Improvement System under the MFP demonstration must address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application and include:

- i. Level of care determinations;*
- ii. Service plan description;*
- iii. Identification of qualified HCBS providers for those participants being transitioned;*
- iv. Health and welfare;*
- v. Administrative authority; and*
- vi. Financial accountability.*

Below is a sampling of 1915(c) HCBS waiver assurances taken from version 3.5 of the 1915(c) HCBS waiver application: level of care determinations; service plan description; identification of qualified HCBS providers for those participants being transitioned; health and welfare; administrative authority; and financial accountability. For each waiver assurance, we have included a desired outcome as well as a narrative description of how Vermont will meet each of the outcomes.

i. Level of Care Determinations

a.i.a Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
a.i.b Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
a.i.c Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Desired Outcome: One-hundred percent of MFP participants will have a level of care evaluation annually.

DAIL Long Term Care Clinical Coordinators (LTCCCs) will perform level of care assessments on all waiver participants and make all level of care determinations using the state’s pre-admission screening instrument, known as the Clinical Eligibility Worksheet. The current process consists

of a review of assessment documents and follow-up phone calls and face-to-face interviews with applicants, as necessary.

With the state staff making the initial level of care determinations, DAIL ensures a more consistent application of the standards used for decision-making. The overall objective of the DAIL clinical oversight processes is to ensure that the services included in care plans are appropriate, both in scope and volume, relative to the identified needs of the individual participants in the demonstration.

Periodic review by the DAIL central office staff of the LTCCCs determinations is in place. This practice provides a second level “check and balance” system for the oversight of LTCCC decisions. Level of care is reevaluated on an annual basis.

ii. Service Plan Description

a.i.a Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
a.i.b Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.
a.i.c Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.
a.i.d Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

Desired Outcome: Services and supports are planned and delivered in accordance with each participant's unique needs and preferences.

Case managers use the results of the Independent Living Assessment as the basis for the development of the individual's plan of care (service plan). Based on the assessment, the individual's circumstances, resources, program eligibility, and formal and informal support systems are reviewed. The case manager also conducts a review of service options and discusses any limitations with the individual and/or their representative. The case manager will, in conjunction with the individual or his/her representative, develop an individualized care plan that includes an array of services based on data from the comprehensive assessment and appropriate to the needs and preferences of the individual.

The comprehensive care plan will also include a back-up care plan in the event of an emergency. The plan will specify not only the services to be provided, but also the quantity in which they are to be provided and the provider designated to deliver each service. Participants and/or their representatives will be encouraged to participate in the care plan development process. The participant and his/her representative will also sign off on the care plan.

The assessment and plan of care are updated at least annually and more often if warranted by changes in the participant's situation or condition. The enrollee is considered to be an active participant in the care planning process and will be notified of any modifications to his/her plan. The case manager will also conduct a review of any new or more appropriate service

options that should be considered with the participant or their representative. The participant will review and sign-off on the revised service plan. The completed re-assessment and signed service plan will be sent to DAIL for a staff level review.

DAIL clinical staff (LTCCCs) will conduct a thorough utilization review prior to authorizing any modifications to the annual service plan. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They also will ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained. They also will monitor, via the Waiver Team meetings, the delivery of services under the care plans.

DAIL monitors the contents of care plans and compares the actual utilization of services by the participant to those services included in the care plan. Other standard monitoring practices include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, resolution, and data analysis.

Comparative analyses are periodically conducted across the plans of care developed by the Area Agencies on Aging versus those prepared by the home health agencies. These comparisons examine the degree of variability among the plans across like populations. Where plans are deemed to be inadequate, a corrective action plan is required and closer monitoring done specific to the individual case manager. The DAIL database is used to further assess the content of the care plans. This system enables the Department to compare and contrast the care plans developed by different agencies across like populations.

iii. Identification of Qualified HCBS Providers for those Participants being Transitioned

a.i.a Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
a.i.b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
a.i.c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Desired Outcome: There are sufficient service providers for the MFP demonstration and they are qualified by licensing, certification, or state regulations.

All participating providers are required to meet DAIL’s licensing and certification requirements or established standards. DAIL has the primary responsibility for ensuring appropriate licensure and certification of all providers. The DAIL central office is responsible for monitoring provider status. Non-licensed, non-certified providers are also required to meet certain standards established by DAIL. For example, all consumer or surrogate directed employees must pass a

background check and may no longer provide care to consumers if they have a disqualifying finding. Any provider found to be out of compliance will be notified of the required corrective action to continue as a demonstration provider.

All case managers must be certified according to the state's procedures, as previously described. Certification remains in effect unless revoked by DAIL or the case management agency. Revocation will occur when there is clear evidence that quality case management services, consistent with DAIL Case Management Standards, are not being provided and/or professional development and training has not been maintained. If a determination is made that an individual case manager is not otherwise performing up to state standards, a discovery and remediation system is activated.

iv. Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation
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Desired Outcome: Participants are safe and secure in their homes and communities.

On the first day of transition, each MFP participant will have a risk mitigation plan, a 24 hour backup plan in place, and a system to report critical incidents. Within six months, the critical incident reporting system will be in place and fully operational to monitor these processes. A summary of these three components is presented below.

24-Hour Back-up System - The first level of backup for all MFP participants will be identified as part of their care plan (the backup plan) and include at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. The plan also will include a list of emergency contacts.

The second level of back-up will be the assigned case manager/case management agency. If the back-up provider on the care plan is not able to resolve the issues for the participant, the case manager (or his/her agency) will be contacted for assistance. Case management agencies are required to offer 24-hour telephone access through an answering service or other means. As a further safety measure, DAIL also plans to contract with Vermont 211 to provide 24 hour backup services for MFP participants, as noted in Section B.6. Consumer Supports. Vermont 211 will provide access to live representatives 24 hours/day, 7 days per week who can draw on resources to meet the needs for critical services and supports. DAIL will be responsible for overseeing the system and will require reports on all calls to monitor responsiveness and timeliness.

DAIL will train VT-211 on all aspects of MFP as well as provide phone numbers to which callers can be referred. MFP participants will be provided with information on the 24 hour backup services in their participant handbooks so they know who to call. MFP QM Specialists will monitor the back-up response system to ensure emergency services are provided timely.

Risk Assessment and Mitigation Process - Transition Coordinators will complete transition assessments on all MFP participants prior to their discharge from a nursing facility. The transition assessment will identify potential risks in transitioning to the community, including situational, environmental, behavioral, medical and financial.

The Transition Coordinator, in collaboration with the participant and the participant's assigned case manager, will develop a care plan. The care plan will identify and document strategies to address the risks identified in the transition assessment as well as an emergency backup plan. Upon completion of the care plan, a copy will be provided to the participant. Care plans will be implemented and monitored by the participant's assigned case manager. The assessment and care plan will be updated at least annually and more often if warranted by changes in the participant's situation or condition.

DAIL clinical staff (LTCCCs) will conduct a thorough utilization review prior to authorizing any modifications to the plan. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals.

They will ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained. They also will monitor, directly or indirectly, the delivery of services

under the care plans and track the proportion of services included in the plan that are actually delivered to the enrollee.

Critical Incident Reporting System - Vermont will ensure appropriate action is taken to address or remediate critical incidents. A “Critical Incident” is any actual or alleged event, incident or course of action involving the perceived or actual threat to an MFP participant’s health and welfare or his/her ability to remain in the community.

Essential to this endeavor will be the ongoing development and implementation of a robust critical incident reporting system to enable MFP staff and DAIL’s QI Committee to:

- Analyze the type and number of complaints from a systemic level
- Look for trends by area and service provider
- Identify statewide issues
- Develop and implement plans for improvement

One element of DAIL’s Quality Improvement Program is the critical incident reporting and management system. Critical incident reporting provides DAIL with data needed to identify and evaluate systemic problems, and to address problems experienced by provider agencies.

Contracted service providers who deliver services to participants, Transition Coordinators, case managers, and any person who becomes aware of a critical incident are required to report the following critical incidents or events to DAIL in the form of an incident report:

- Allegations or suspicion of abuse, neglect or exploitation of a vulnerable adult

- Untimely death of a person
- Missing Person
- Use of a Restraint
- Unexpected hospitalizations
- Injuries requiring medical treatment
- Medication errors
- Events or incidents that cause harm to MFP participants or serve as indicators of risk to participants' health and welfare
- Other critical incidents such as a fire, theft or destruction of property, criminal act or unusual events.

DAIL will be the responsible state agency for overseeing the reporting of and response to critical incidents for MFP participants. In this capacity, DAIL will be responsible for all of the following:

- Developing and implementing an internal incident reporting and management system;
- Implementing procedures to address identified risks;
- Training Transition Coordinators, case managers, DAIL staff and its contractors, providers, participants and the general community on its critical incident reporting system and processes;
- Evaluating provider agency response to incidents;
- Providing technical assistance to providers;
- Maintaining an incident report database;

- Producing reports related to the information collected; and
- Analyzing incident report data as a risk management tool and develop a plan of action to prevent reoccurrences

DAIL also is beginning an initiative in SFY 2012 with the Albany College of Pharmacy whereby advance practice students will be reviewing medications of Choices for Care participants referred to them for appropriateness and contraindications. MFP participants will be one of the initial target populations to be monitored under this initiative.

Training

MFP Transition Coordinators, in collaboration with Quality Management Specialists, will train case managers, DAIL staff and its contractors, providers, participants and the general community on DAIL's critical incident reporting system and processes. Training will be tailored to each audience and will include, but not be limited to, such topics as: abuse, neglect and exploitation; how to complete DAIL's incident report form; the types of critical incidents; the investigation and remediation process; reportable incidents; and responsible entities.

In addition to providing training, DAIL representatives will conduct oversight of staff and contracted providers to ensure critical incident reporting policies are being followed.

Corrective action will be taken as needed to ensure these entities comply with critical incident reporting requirements.

Critical incidents will be monitored on a case-by-case basis to assure timely, adequate and complete resolution. In light of this, DAIL will dedicate one Quality Management Specialist to be the responsible entity to review critical incident reports and act upon them if individual remediation and/or system improvement is needed. The critical incident reporting process will be the same for all MFP and Choices for Care waiver participants. DAIL's QI Committee will be the responsible entity that will oversee and verify that processes were followed and appropriate actions were taken.

Critical Incident Reporting

Contracted service providers, Transition Coordinators, case managers, and any person who becomes aware of a critical incident will be required to complete DAIL's incident report form (a copy of the form is included in Appendix H). The person completing the form will send it to DAIL's MFP QM Specialists by fax, electronically (accessible via the DAIL's website) or in person no later than 24 hours from the critical event. While an initial verbal report is allowable, a written report is required within 48 hours of the incident.

DAIL's Incident Reporting process does not substitute for the reporting requirements of other agencies. Harm to vulnerable individuals must be reported to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Program Integrity Unit for follow-up.

DAIL will ensure a process is in place to protect the participant pending completion of a review/investigation. Each process will depend on the individual circumstance as it relates to the incident and may include more intensive case management, revising the participant's care plan and backup plan to substitute or add services, frequent site visits to the participant's qualified residence and/or reassessment of the participant's needs.

In addition to the formal incident reporting process, DAIL program standards require case managers to have at least monthly contact with participants. This practice helps instill a degree of confidence in the safety and welfare of the participants. Case managers also are responsible

for assessing risk during the initial assessment, on an annual basis and as needed in the event of a status change. Care plans and emergency backup plans are revised as necessary to factor in any new levels of risk.

Investigation

DAIL's QM Specialists will respond to each incident based on individual need and significance. The QM Specialists will date stamp all reports upon receipt and enter report information into the critical incident database. Copies of all incident reports will be maintained in the MFP participant's file and reviewed as part of the MFP Quality Assurance process.

If the critical incident involves a contracted provider or subcontractor, the designated QM Specialist will require the provider to conduct an internal critical incident investigation and submit a report on the investigation. The QM Specialist will review the report and ensure that appropriate interventions were taken. If an adequate response was taken, no further action will be necessary.

However, for an inadequate response, the MFP Project Director will be notified and will contact the provider to discuss the areas in which the response was found to be inadequate. The Project Director may request a Critical Incident Improvement Plan and will notify the QM Specialist that a plan has been requested.

Complaints of abuse, neglect and exploitation will be referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Program Integrity Unit for follow-up as appropriate or as required by Vermont Statute.

For all other critical incidents, the DAIL MFP QM Specialists will investigate through a multidisciplinary review that involves key stakeholders involved in the incident. The investigation will incorporate the following information:

- Circumstances leading up to and culminating in the critical incident;
- Any current practice, procedure or factor involved in providing the service that contributed to the occurrence of the critical incident;
- Actions considered, developed or required as follow up to the critical incident; and
- Implementation of any recommendations resulting from the critical incident review.

Remediation

The appropriate action will be taken to resolve the critical incident and a Critical Incident Improvement Plan will be developed. If the critical incident involves a contracted provider or subcontractor, the involved entity, in consultation with QM Specialists, will develop a plan which addresses the actions to be taken to prevent reoccurrences, or to improve response in the event of similar incidents, a date by which the actions will be taken, and the provider agency staff responsible for taking the actions.

The provider will submit the plan to the QM Specialists upon completion. The designated QM Specialist will monitor the progress of the plan by following up with the appropriate provider or entity to obtain timely receipt of the plan and to assess the adequacy of its implementation. Feedback/direction will be provided to appropriate stakeholders to implement quality improvements as required.

During any review, when DAIL encounters situations in which a participant's health and welfare are at risk, staff will follow a protocol to report the observation and ensure the health and welfare of the participant. Operating agencies are required to respond with a corrective action plan depending on the severity of the situation.

DAIL contracts with Vermont Legal Aid for Long Term Care Ombudsman services for all individuals served through the program. This will ensure that all program participants have access to an independent entity responsible for representing their interests.

All critical incidents will be reported to DAIL's QI Committee, which will be the responsible entity for verifying that required processes were followed and appropriate actions were taken. The Committee also will review findings to determine whether additional follow-up is required and to identify any necessary system adjustments or best practices.

The QI Committee will review reports that are generated by the incident report database to identify trends that may need to be responded to by remediation and to identify improvement

activities. The QI Committee will review the adequacy of the response to the critical incident report and determine the closure of reports. Remediation is assured and tracked on a case-by-case basis.

Critical Incident Tracking and Quality Assurance

The QM Specialists will maintain an incident report database to track incidents; monitor technical assistance and dispositions (including requests for additional information regarding incidents and status of Critical Incident Improvement Plans); and conduct tracking and analysis of critical incident trends.

Reports will be run quarterly and reviewed to ensure that appropriate action was taken at the time of the incident. Reports will be provided to DAAL's QI Committee and reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate and/or prevent any recurrence of the incident. Following is a list of data elements that will be tracked for MFP participants:

- Number and type of reportable critical incidents, by type;
- Average (mean/median) number of critical incidents per waiver participant;
- Number and percent of critical incidents requiring investigation, by type;
- Number and percent of critical incidents substantiated, by type;
- Number and percent of critical incidents investigated within required timeframe;

- Number and percent of critical incidents for which corrective actions were verified within required time frame; and
- Number of waiver participant deaths from unexplained or suspicious causes

v. Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Desired Outcome: The system operates the MFP waiver program effectively and ensures a comprehensive quality structure is in place.

DAIL and the Department of Vermont Health Access (DVHA) are both departments within the Vermont Agency of Human Services. As Vermont's Medicaid agency, DVHA retains ultimate administrative authority and responsibility for the operation of the waiver program. DAIL will be responsible for day-to-day administration of the MFP demonstration. This is the same structure as employed for the Choices for Care waiver.

vi. Financial accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Desired Outcome: MFP claims are coded and paid are in compliance with waiver requirements.

AHS will ensure through its Medicaid Management Information System (MMIS) and its claims processing contractor (Hewlett Packard) that there is no duplication of payments for services

rendered through the various Medicaid waivers and programs. The MMIS contains logic to identify duplicate claims, regardless of the funding source/program, thereby preventing duplication of payment.

The MMIS maintains a "Demographic Modifier" table that is used to match Medicaid enrollees to specific programs, including the Choices for Care 1115 Waiver. The Demographic Modifier table includes the recipient ID and the start/end dates for enrollment in these specific programs. The Demographic Modifier logic enables the system to assign payment responsibility to a specific funding source, as well as maintain other edits.

For non-MMIS services, the state relies on a number of other reporting and monitoring tools to prevent duplicative payments. The Medicaid program and DAIL also have policies and procedures to ensure that financial reporting and monitoring for non-Medicaid funded programs, such as the Older Americans Act, are coordinated with Medicaid funded programs.

The Medicaid Provider Participation Agreement prohibits providers from billing Medicaid (as the payor of last resort) for any service that has been reimbursed or funded by another source. The state's Medicaid Program Integrity Unit monitors compliance with this requirement through periodic claims reviews and provider audit activities.

Oversight and monitoring of the Intermediary Service Organization (ISO) for employer support services within the consumer and surrogate-directed services program is conducted via monthly meetings and through data submission and claims review.

- d. If the State provides supplemental demonstration services (SDS), the State must provide:*
- 1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,*
 - 2. A description of the remediation and improvement process.*

Vermont is not proposing to offer supplemental demonstration services.

B.9 Housing

a. Describe the State's process for documenting the type of residence in which each participant is living (See chart for examples in Sub-Appendix II). The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting, such as:

- i. Owned or rented by individual,*
- ii. Group home,*
- iii. Adult foster care home,*
- iv. Assisted living facility, etc. (Please see the Policy Guidance in Sub-Appendix VI)*

Vermont will secure housing for MFP participants in a "qualified residence" as defined in Section 6071 (b)(6) of the Deficit Reduction Act. There will be four types of qualified residential settings from which MFP participants can choose:

1. A home owned or leased by the individual or the individual's family member; this option is not regulated by the state and the lease is maintained with the landlord or owner.
2. An apartment with an individual lease is a residential type that can be in an apartment building, assisted living facility, and/or public housing unit. The apartment will have lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control. Apartments are regulated. An apartment building is regulated by the lease and held by the landlord. An assisted living facility is regulated by the state, and public housing units are regulated through Section 8 by the Vermont State Housing Authority.

3. A residence, in a community-based residential setting, in which no more than four unrelated individuals reside. These types of community based settings can include: group homes (not applicable to MFP), Licensed Level III Residential Care (including enhanced residential care), and Assisted Living Residences. These three types of community based alternative residential settings are regulated by DAIL, Division of Licensing and Protection.

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4. A residence, in a community based residential setting, in which one or two individuals unrelated to the caregiver reside. These will all fall under the category of Adult Family Care homes. They will be required to meet health and safety standards established by DAIL and will be monitored regularly by Community Development staff and case managers. They will not be formally licensed by DAIL's Division of Licensing and Protection, however.

Transition Coordinators in coordination with Community Development Specialists will discuss all housing and service options with participants. The participant or his/her authorized representative must approve the selection of the qualified residence in which the individual will reside. Once the decision is made, the Transition Coordinator will document the type of residence where each participant chooses to live in the participant's transition plan.

Transition Coordinators will submit transition plans to DAIL that include the choice of housing at least 30 days prior the transition. Information on the type of qualified residence that the individual chooses must be verified and approved by the Transition Coordinator prior to the

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individual's discharge from the nursing facility. Verifications may be made through a visit to the residence, a report of the consumer or representative, information obtained from the property manager or landlord, licensure information or information from a local housing authority.

Approval will be given in writing and will become part of the participant's file. Information about the community residence chosen by each participant will be documented and reported to the state and CMS using the report format presented in Sub- Appendix II of the application instructions.

Once the individual is enrolled in the MFP demonstration, the participant's case manager will be responsible for monitoring and reporting any changes in the participant's qualified residence. The case manager will report this information to DAIL for tracking purposes using a "Change in Status Form".

b. Describe how the State will plan to achieve a supply of qualified residences so that each eligible individual or the individual's authorized representative can choose a qualified residence prior to transitioning.

i. Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions;

Transition to a community residence will be dependent on having a sufficient supply of qualified residences in the service area of the potential participant. Keeping in mind the projected number of MFP participants each year and the fact that the program encompasses the entire state of Vermont, this will require a concerted effort between the Agency of Human

Services, DAIL, Division of Licensing and Protection, Vermont Housing and Conservation Board, Vermont Public Housing Authority and other partnering organizations.

Under MFP, Community Development Specialists will be contracted by DAIL to identify and coordinate housing options for persons moving out of nursing facilities into the community. An inventory of available qualified residence options will be developed by the Community Development Specialists to assist Transition Coordinators and participants with community placement.

Community Development Specialists also will disseminate housing information to other stakeholders in the community setting, such as families, caregivers, guardians and advocates. They will conduct outreach to build capacity, particularly for the new Adult Family Care housing option and will participate in housing workgroups and work with housing agencies to address supply issues.

ii. Explain how the State will plan to address any identified housing shortages for persons transitioning under the MFP demonstration grant:

Community Development Specialists will work on a routine basis to expand housing options and capacity in their assigned geographic areas. If a shortage emerges, outreach and recruitment efforts will be intensified, including through temporary placement of additional MFP staff to aid in recruitment activities. Community Development Specialists also will foster relationships with town officials and housing providers and organize ad hoc housing work groups to address specific needs. They will ensure that placement options requiring environmental modifications are not overlooked as part of the recruitment process.

In addition, Community Development Specialists will consult with their counterparts in the area responsible for recruiting providers to operate Developmental Disabilities Services (DDS) homes. These residences are similar to Adult Family Care homes and the Developmental Disabilities Services component of DAIL has extensive experience devising strategies to address shortages in DDS Home capacity when they occur.

iii. Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and

As discussed above, Vermont is moving forward with the addition of a new Qualified HCBS option, the Adult Family Care Home. This alternative residential setting will increase the capacity of affordable/accessible housing options for the older adults and physically disabled residents in Vermont and will be available both to MFP participants and other Choices for Care enrollees. However, Vermont is aware that, like in most other states, the lack of affordable/accessible housing poses one of the greater challenges to rebalancing the long term care system.

DAIL is, and will continue to work with housing authorities throughout the state on expanding housing options and capacity. This will occur through the ad hoc MFP committee, which was originally created by DAIL to explore new housing options and has played a leading role in defining the Adult Family Care benefit. DAIL's partners in this effort include but are not limited to the Office of the LTC Ombudsman, Area Agencies on Aging, the Vermont Center for

Independent Living, the Vermont Housing and Conservation Board, the regional office of the Department of Housing and Urban Development and the Vermont Coalition for Disability Rights.

iv. Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants:

Vermont recognizes that working in partnership with housing professionals is essential to assuring a supply of accessible and affordable housing options. We also understand from CMS training sessions that there is a definite link between housing availability and MFP participant ability to meet transition targets. This recognition was the impetus for the state's decision to identify the role of the Community Development Specialists described above and add Adult Family Care as a Qualified HCBS benefit.

The state is confident its strategy will expand affordable and cost effective housing options over the life of the demonstration. A portion of the savings achieved may be used to increase reimbursement for adult family care providers who specialize in serving participants with particularly complex needs, as a way to further increase capacity.

B.10 Continuity of Care Post Demonstration

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:

a. Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:

- i. 1915(b) waivers and managed care contracts are amended to include the necessary services*
- ii. appropriate HCBS are ensured for the eligible participants; or*
- iii. A new waiver will be created.*

MFP participants will not be transitioning into a 1915(b) waiver as part of this demonstration.

b. Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:

- i. capacity is available under the cap;*
- ii. A new waiver will be created; or*
- iii. There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915(c) waiver.*

MFP participants will not be transitioning into a 1915(c) waiver as part of this demonstration.

c. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:

- i. Slots are available under the cap;*
- ii. A new waiver will be created; or*
- iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver*

Vermont plans to continue all Qualified HCBS benefits after the MFP demonstration.

Participants in the Vermont MFP demonstration will receive home- and community-based services through the existing 1115 demonstration program, Choices for Care, and will therefore experience no interruption at the end of their participation in the demonstration.

Unlike some other Section 1115 waivers, Choices for Care does not have a cap on HCBS slots.

Enrollees in the Highest and High Need categories (which include nursing facility residents) are entitled to choose between HCBS and nursing facility care. High Needs individuals are served to the extent funding is available. As of April 1, 2011, Choices for Care applicants who meet High Needs criteria are not subject to a wait list. In addition, it is anticipated that all new MFP participants will already be enrolled on Choices for Care in the nursing facility receiving LTC Medicaid when they are identified as an eligible MFP participant. In general, individuals who are currently enrolled on Choices for Care continue enrollment as long as they meet High or Highest Needs clinical criteria (in addition to all other eligibility criteria). Therefore it will not be necessary to reserve slots for MFP participants through an amendment to the waiver.

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d. State Plan and Plan Amendments - for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no disruption of services when transitioning eligible participants from the demonstration program

State plan optional services will not be used for Vermont's MFP demonstration.

C. PROJECT ADMINISTRATION

Provide a description of the day to day organizational and structural project administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:

1. Organizational Chart: Provide an organizational chart that describes the entity that is responsible for the day to day management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and supports and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.

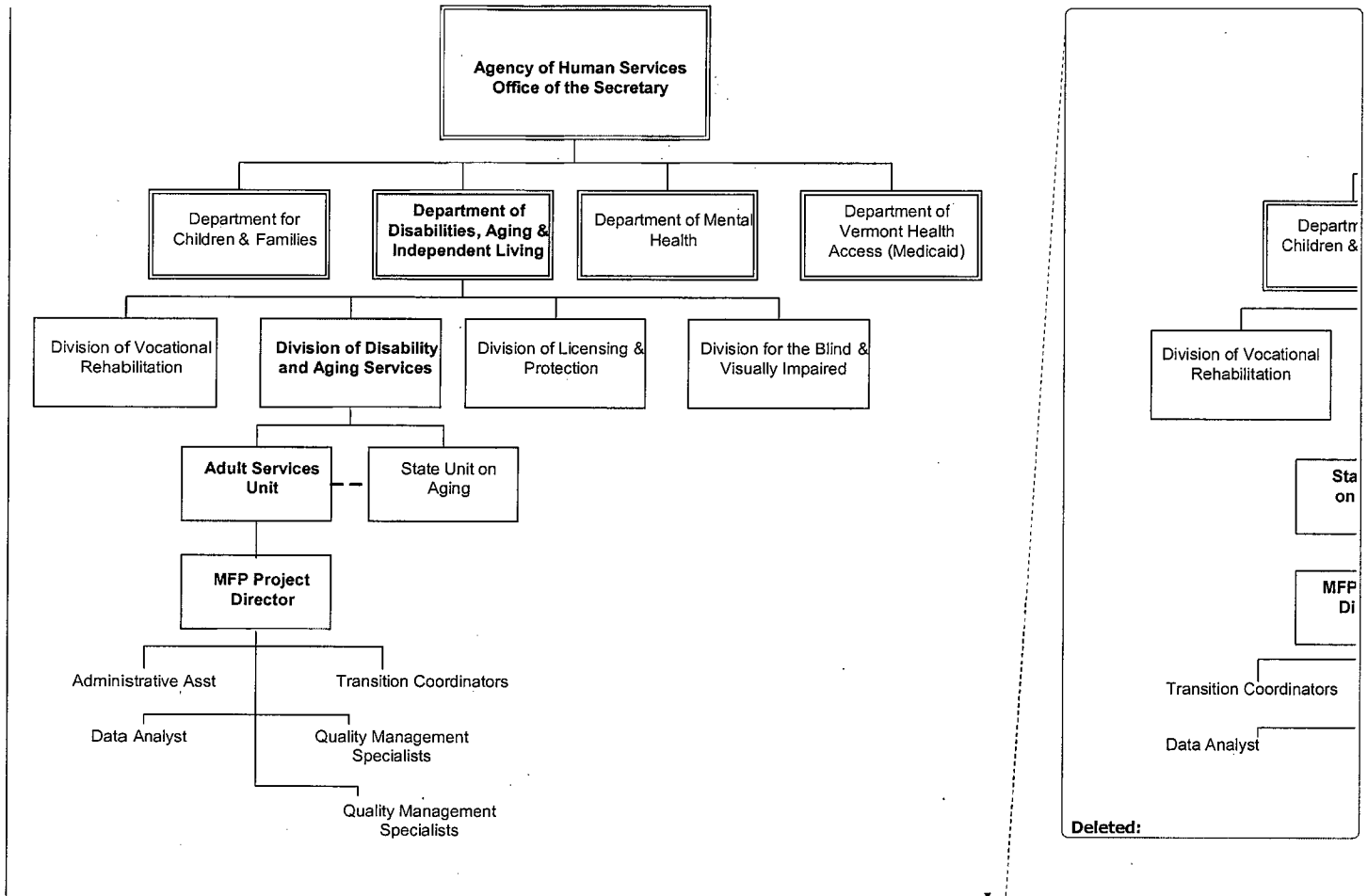
The Department of Disabilities, Aging and Independent Living (DAIL), within the Agency of Human of Services (AHS) will be responsible for day-to-day management of the grant. DAIL will operate the MFP demonstration from within the Adult Services Unit. DAIL already oversees all aspects of the Choices for Care waiver, and will manage MFP as a fully integrated component of the waiver.

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DAIL will coordinate activities with the state’s Medicaid agency, the Department of Vermont Health Access (DVHA), which is also located within AHS. DAIL and DVHA work closely together today on administration and reporting activities for Choices for Care.

Other partner agencies residing within AHS include the Department for Children and Families/Economic Services Division (DCF/ESD), which is responsible for financial eligibility determination and the Department of Mental Health. Exhibit 11 below presents the organizational structure for administration of the demonstration. (This is identical to the structure shown in Exhibit 2.)

Exhibit 11 – Demonstration Organizational Structure



2. Staffing Plan: Provide a staffing plan that includes:

a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume or Job Description including performance evaluation criteria (CMS pays 100% of the cost of this position, CMS will have input into the approval of the person hired. At any time CMS feels that the individual is not performing up to our expectations, CMS may request that a new Project Officer be assigned.)

Megan Tierney-Ward, Medicaid Waiver Supervisor in the Adult Services Unit, will serve as the Interim Project Director for this demonstration and will have day-to-day responsibility for the

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operation of the project until a permanent position is filled. DAIL assures that the Project Director will be a full-time position and CMS will have input into the approval of the person hired. A job description for the Project Director position is located in Appendix I.

- b. The number and title of dedicated positions paid for by the grant and a justification of need. Please indicate the key staff assigned to the grant, if they have been identified.*
- c. Percentage of time each individual/position is dedicated to the grant.*
- d. Brief description of role/responsibilities of each position.*

Vermont's MFP staffing plan includes a funding request for 7.5 FTE staff positions to be dedicated solely to demonstration activities. The state is making a significant staffing commitment in recognition of the complex needs and challenging nature of the population being targeted for transition back to the community. The plan also takes into account Vermont's largely rural population and the need to have field-based staff located throughout the state.

The number and title of dedicated positions, percentage of time each individual is dedicated to the grant, brief description of roles/responsibilities and a justification of need are presented in Exhibit 12 below.

Exhibit 12 – Vermont MFP Staffing Plan

FTEs	Title	% of Time	Roles/Responsibility	Justification of Need
1	Project Director	100	The Project Director is responsible for leading the design, development, implementation and plans for sustaining the CMS MFP demonstration. Also oversees training activities	CMS required position; CMS pays 100% of the cost of this position
0.5	Administrative Assistant	100	A half-time clerical position to support the Project Director, the Steering Committee and workgroups	Position is a new hire dedicated to the project; therefore 100% federal funding is requested
3	Transition Coordinators	100	Identify candidates for MFP demonstration; respond to nursing facility referrals; perform transition planning and transition assessments in nursing facilities; communicate potential enrollee information to case managers and work with case managers to develop a care plan and to identify and coordinate specialized supports; work with community development specialists to arrange housing options; and provide transition follow-up as necessary to support the participant and case manager	Positions are new hires dedicated to the project; therefore 100% federal funding is requested
1	MFP Data Analyst	100	Receive and collate documentation for clinical review and approval; perform data collection, analysis and complete required MFP reports; develop and update the MFP portion of DAIL's website; assist quality staff to manage program tracking systems	Position is a new hire dedicated to the project; therefore 100% federal funding is requested

FTEs	Title	% of Time	Roles/Responsibility	Justification of Need
2	QM Specialists	100	Oversee 24/7 back-up system, critical incident and reporting system, and risk mitigation programs; perform all required QM and utilization review activities; assist with independent evaluation as necessary; assist in writing the operational protocol and analyzing data related to the demonstration; manage all requirements related to internal, state and federal reporting, tracking, and data management, including management of MFP benchmarks; oversee certification and licensure reviews of clinical staff and housing; interface with CMS and DAIL on integrity of required data systems; grant financial and performance reporting	Positions are new hires dedicated to the project; therefore 100% federal funding is requested

e. Identify any positions providing in-kind support to the grant.

At the present time, due to the nature of the work intensity required for this project, there will not be any existing positions providing in-kind support to the grant.

f. Number of contracted individuals supporting the grant.

Two Community Development Specialists will be contracted to assist in identifying qualified residences for MFP participants and developing strategies for increasing available affordable and accessible housing. The Community Development Specialists also will participate in housing workgroups and forums; develop and perform community outreach & marketing across the state; develop a comprehensive list of transportation and other supportive assistance options; perform referral support functions; and support training initiatives. The state believes the expertise to provide this service can best be obtained through competitively bid contracts with organizations devoted to expanding housing options for the state's vulnerable populations.

Comment [WU7]: The transition consultant contract was removed in order to comply with the CMS 20% admin cap.

Exhibit 13 below summarizes the key responsibilities of the hired and contracted positions, and illustrates how they will interact with each other and with participant case managers.

Exhibit 13 – Vermont MFP Staff Responsibilities and Interactions

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Vermont also will contract with organizations that do not act as direct service providers to serve as consultants to Transition Coordinators. These will likely include a combination of the Vermont Center for Independent Living, Area Agencies on Aging, Designated Agencies, State Independent Living Council, HomeShare Vermont and other local organizations familiar with Vermont's supportive home- and community-based services. ¶

Outreach and Market Development	Identification of MFP Candidates	Transition Planning	Service Planning	Service Delivery
Transition Coordinator	Transition Coordinator	Transition Coordinator		
Meet with nursing facility discharge planners on monthly basis	Meet with member and member's family. Perform transition assessment	Facilitate transition planning, including meetings with member and family, Community Development Specialist, MFP consultants and Case Manager. Also assist with training activities		
Community Development Specialist		Community Development Specialist		
Ongoing activities to identify and expand housing options		Identify housing options and assist member with reviewing options and selecting new home. Also assist with training activities		
		Case Manager	Case Manager	Case Manager
		Participate in transition planning	Responsible for care planning and oversight	Ongoing communication. Ensure service delivery in accordance with care plan
QM Specialist and Data Analyst	QM Specialist and Data Analyst			QM Specialist and Data Analyst
Monitoring of service capacity and program awareness	Monitoring of compliance with MFP Operational Protocol and Performance Benchmarks			Evaluate performance data (compliance with care plan, satisfaction)
		QUALITY		

g. Provide a detailed staffing timeline.

Megan Tierney-Ward, Medicaid Waiver Supervisor in the Adult Services Unit, will serve as the Interim Project Director for this demonstration and will have day-to-day responsibility for the operation of the project until a permanent position is secured. The search will commence for a permanent director upon grant award. The project director and the administration assistant will be hired simultaneously. Recruitment for all other state staff, including contracted

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personnel, will begin immediately, although final hiring decisions will be made in consultation with the permanent project director, once he or she has been hired.

Exhibit 14 below presents the detailed staffing timeline.

Exhibit 14 – Vermont MFP Staffing Timeline

Title	Sourcing Option	RFP or Candidate Interviews	Candidate/ Contractor Begins
1 Project Director	Hire	5/1/11	6/1/11
0.5 Administrative Assistant	Hire	5/1/11	6/1/11
3 Transition Coordinators	Hire	5/1/11	7/15/11
2 Community Development Specialists	Contracted	5/1/11	7/15/11
1 MFP Data Analyst	Hire	5/1/11	7/15/11
2 QM Specialists	Hire	5/1/11	7/15/11

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Exhibit 15 presents a sample staff training outline.

Exhibit 15 – Sample Staff Training Outline

Week 1:	Week 2:	Week 3:
Mission/Goals/Philosophy AHS/DAIL/DDAS org chart AHS Personnel Tour DAIL & State Complex DAIL Division Presentations History of VT Long-Term Care Choices for Care (CFC) MFP Overview MFP Eligibility Role of MFP staff Self-determination/Negotiated Risk Guardian Services	CFC Home-Based Option/Flexible Choices/PACE Residential Care/ERC/ACCS Nursing Facility Care Provider Presentations (AAA, HHA) CFC Moderate Needs Services Dementia Respite Grant Emergency Planning CFC Forms & Utilization Review MDS/DLP ADRC	Nursing Home Provider Tours (statewide) Waiver Team Visits (Statewide) Provider Presentations (RCH, NF) VCIL Presentation HomeShareVT Presentation SAMS database Introduction Provider visits/tours Independent Study on Specified Materials

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Independent Study (manual & regulations)	Provider visits/tours Independent Study on Specified Materials	
<u>Week 4:</u>	<u>Week 5: (if needed)</u>	<u>Week 6: (if needed)</u>
Shadow DAIL LTCCCs & Providers Continue Waiver Team Visits Quality Management Overview Medicaid Fraud Presentation DVHA Program Integrity Continue SAMS database training Independent Study on Specified Materials	Shadow DAIL LTCCCs & Providers DAIL Legal Office presentation (appeals) HIPAA/Confidentiality POA/Guardianship Advanced Directives ADA Continue SAMS database training Independent Study on Specified Materials	Shadow DAIL LTCCCs & Providers Continue SAMS database training

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h. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.

DAIL will be the lead entity for the MFP demonstration within AHS and will be responsible for the assessment of performance of the staff involved in the demonstration.

Billing and Reimbursement Procedures. Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

Billing and reimbursement will be managed through the systems currently used for Vermont's waiver services. DAIL has extensive fraud control and financial monitoring systems in place. The Vermont Medicaid Fiscal Intermediary, in concert with the Economic Services Division (ESD)

claims payment system, is programmed to deny duplicate claims for waiver services that will be utilized under MFP.

DAIL and the state's fiscal agent (Hewlett Packard) monitor for fraudulent claims billings through these tracking systems and through consumer complaints. Provider manuals address the requirements for provider documentation. There is no anticipation of change to the current system other than those specified by the demonstration grant for reporting purposes.

Prior to claims processing, the automated claims management system edits claims for validity of the information and compliance with business rules for the service/program and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current authorized care plan contains sufficient units to cover amounts claimed, and that an authorized level of care is registered in the claims management system, the claim will be rejected.

Current procedures provide for fiscal review to examine the provider agency's service delivery and financial records, and to verify that all payments are made to the provider agency were supported and documented. The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, all improper payments can be recovered. The state also recovers payments when it verifies the provider was overpaid because of improper billing. The state may take adverse action against the provider or require a corrective action plan for any fiscal review findings.

D. EVALUATION

Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP demonstration. If these activities are undertaken by the State, the following information must be provided to CMS:

*1. **Evaluator:** If an evaluator has been identified, name the evaluator and provide a resume of the principle investigator in an indexed appendix. Provide a description of the process that will be used to secure an evaluator if one has not yet been identified. Also provide a description of how the State will assure that the evaluator will possess the necessary expertise to conduct a high quality evaluation. Provide a brief description of the organizational and structural administration that will be in place to implement, monitor and operate the evaluation.*

*2. **Evaluation Design:** Provide a description of the State's evaluation design. The description should include the following:*

- a. A discussion of the demonstration hypotheses that will be tested;*
- b. The outcome measures that will be included to evaluate the impact of the demonstration;*
- c. The data source that will be utilized;*
- d. An analysis of the methods used for data collection;*
- e. The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration;*
- f. The method that will be utilized to isolate the effects of the demonstration from other state initiatives and state characteristics (e.g. per capita income and/or population);*
- g. Any other information pertinent to the State's evaluative or formative research via the demonstration operations; and*
- h. Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)*

*3. **Variables:** Describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the application. Describe the instruments and provide a rationale for their use in the evaluation including reliability, validity and appropriateness for use on the study population.*

*4. **Process Evaluation:** Please describe how process measures will be evaluated. Include a description of how infrastructure changes will be evaluated as well as any pilot programs.*

Vermont contracts with the University of Massachusetts to conduct the independent evaluation of the Choices for Care waiver. The state may ask the University to undertake evaluation activities related to the MFP demonstration sometime in the future. However, the state at this

time is not proposing to conduct an independent evaluation of the demonstration. Vermont will fully support the national evaluator in accordance with grant requirements.

E. BUDGET

1. Administrative Budget Presentation: (An electronic submittal form will be provided by CMS)

Please address the following items:

- a. Personnel
- b. Fringe benefits.
- c. Contractual costs, including consultant contracts.
- d. Indirect Charges, by federal regulation.
- e. Travel
- f. Supplies
- g. Equipment
- h. Other costs

Exhibit 16 below presents Vermont's proposed administrative budget, by expense category, for each calendar year of the demonstration.

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Exhibit 16 – Vermont MFP Administrative Budget

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Category	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Personnel	\$260,590	\$347,454	\$360,131	\$371,852	\$384,384	\$ 99,363
Fringe Benefits	\$114,008	\$152,011	\$157,557	\$162,685	\$168,168	\$ 43,471
Contractual	\$52,500	\$92,400	\$94,872	\$97,418	\$100,041	\$25,685
Travel	\$ 25,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000
Supplies	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000
Equipment	\$20,000	---	---	---	---	---
Other costs	\$ 84,000	\$ 55,000	\$ 55,000	\$ 55,000	\$ 55,000	\$ 55,000
<i>Sub-Total</i>	<i>\$563,098</i>	<i>\$678,865</i>	<i>\$699,561</i>	<i>\$718,956</i>	<i>\$739,592</i>	<i>\$255,520</i>
Indirect Charges*	\$28,155	\$33,943	\$34,978	\$35,948	\$36,980	\$12,776
TOTAL	\$591,253	\$712,808	\$734,539	\$754,903	\$776,572	\$268,296

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*Indirect charges set at 5 percent of expenditures

2. Administrative Budget: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Please indicate any administrative fund request to be reimbursed fully through the grant. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

The following section provides detailed information for Vermont's proposed administrative expenditures for the five years of the demonstration.

a. Personnel

- **Project Director** – The Project Director is responsible for leading the design, development, implementation and plans for sustaining the CMS MFP demonstration. The Director also will oversee all training activities. DAIL assures that the Project Director will be a 100 percent CMS funded full-time position and CMS will have input into the approval of the person hired.
 - The total cost for CY 2011 is \$49,483.
 - The total cost over the life of the demonstration is \$315,009 (this figure includes an annual inflation rate of three percent).

- **Administrative Assistant** – One half-time clerical position will be dedicated 100 percent to the demonstration and will support the Project Director and workgroups. Vermont is requesting this position be fully reimbursed through the MFP demonstration grant.
 - The total cost for CY 2011 is \$17,670.
 - The total cost over the life of the demonstration is \$112,266 (this figure includes an annual inflation rate of three percent).

- **Transition Coordinators** – Three full-time Transition Coordinators will be hired and located in the north, middle and southern regions of the state. Transition Coordinators will have RN or MSW credentials and will have the following roles/responsibilities: respond to nursing facility referrals; provide referral and support functions; perform transition planning and transition assessments in nursing facilities; communicate potential enrollee information to Choices for Care case managers and work with Choices for Care case managers to develop a care plan and to identify and coordinate specialized supports; work with community development specialists to arrange housing options; provide transition follow-up as necessary to support the participant and case manager; and assist with training activities. Vermont is requesting these positions be fully reimbursed through the MFP demonstration grant since they will be 100 percent dedicated to the grant and play a major role in achieving increases in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program and who receive a transition packet each year, as well as assisting with the safe transition of residents back into the community.
 - The total cost for CY 2011 is \$140,150.
 - The total cost over the life of the demonstration is \$890,726 (this figure includes an annual inflation rate of three percent).

- **MFP Data Analyst** - One full-time Data Analyst position will be dedicated 100 percent to the demonstration and will be responsible for the following: receive and collate documentation for clinical review and approval; perform data analysis and complete

required MFP reports; develop and update the MFP portion of DAIL's website; and assist quality staff to manage program tracking systems. Vermont is requesting this position be fully reimbursed through the MFP demonstration grant.

- The total cost for CY 2011 is \$46,717.
 - The total cost over the life of the demonstration is \$296,909 (this figure includes an annual inflation rate of three percent).
-
- **Quality Management Specialists** – Two Quality Management Specialists will be hired to perform the following functions: oversee 24/7 back-up system, critical incident and reporting system, and risk mitigation programs; perform all required QM and utilization review activities; assist with independent evaluation as necessary; assist in writing the operational protocol and analyzing data related to the demonstration; manage all requirements related to internal, state and federal reporting, tracking, and data management, including management of MFP benchmarks; oversee certification and licensure reviews of clinical staff and housing; interface with CMS and DAIL on integrity of required data systems; and grant financial and performance reporting. The positions will be dedicated 100 percent to the demonstration and will assist the state in achieving the annual benchmarks by collecting and analyzing data for each of the five benchmarks as well as providing ongoing monitoring of all MFP program activities.
 - The total cost for CY 2011 is \$93,434.
 - The total cost over the life of the demonstration is \$593,817 (this figure includes an annual inflation rate of three percent).

b. Fringe benefits

The fringe benefit rates for each year are 43.75 percent and are included in Exhibit 14.

c. Contractual costs

- **Community Development Specialists** – Two Community Development Specialists will be contracted to perform the following functions: identify the qualified residences for MFP participants; develop strategies for increasing available affordable and accessible housing; participate in housing workgroups and forums; develop and perform community outreach and marketing across the state; develop a comprehensive list of transportation and other supportive assistance options; perform referral support functions; and assist with training activities. The positions will be dedicated 100 percent to the demonstration and will assist the state in achieving the annual benchmarks of increasing in the number of participants that secure community housing and to meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence.
 - The total cost for CY 2011 is \$80,000.
 - The total cost over the life of the demonstration is \$517,473 (this figure includes an annual inflation rate of three percent).

- **Vermont 211** – The state will contract with Vermont 211 services to provide 24/7 toll-free backup services to MFP participants. Therefore, 100 percent federal funding is requested for this contracted service.

Comment [WUB]: The transition consultant contract was removed in order to comply with the CMS 20% admin cap.

Deleted: ~~including consultant contracts~~

Deleted: ~~<#>Transition Consultants – Vermont will contract with organizations that do not act as direct service providers to serve as consultants to Transition Coordinators and will perform similar functions. These will likely include a combination of the Vermont Center for Independent Living, Area Agencies on Aging, Designated Agencies, State Independent Living Council, HomeShare Vermont and other local organizations familiar with Vermont’s supportive home- and community-based services. Vermont is requesting these consultants be fully reimbursed through the MFP demonstration grant since they will be 100 percent dedicated to the grant and play a major role in achieving increases in the number of Medicaid-eligible nursing facility residents who are informed of the MFP program and who receive a transition packet each year, as well as assisting with the safe transition of residents back into the community. ¶ <#>The total cost for CY 2011 is \$200,000. ¶ <#>The total cost over the life of the demonstration is \$1,293,682 (this figure includes an annual inflation rate of three percent). ¶ <#> ¶~~

○ The total cost for CY 2011 is ~~\$2,917~~.

Deleted: 5,000

○ The total cost over the life of the demonstration is ~~\$24,164~~.

Deleted: 30,000

- **Interpreters Referral Services** – Vermont will contract with an interpreter service to provide telephone translation at no cost. The service will be free to MFP participants.

Therefore, 100 percent federal funding is requested for this contracted service.

○ The total cost for CY 2011 is ~~\$2,917~~.

Deleted: 5,000

○ The total cost over the life of the demonstration is ~~\$24,164~~.

Deleted: 30,000

d. Indirect charges, by federal regulation

Vermont is applying an indirect charge rate of five percent.

e. Travel

Travel costs cover field-based activities for Transition Coordinators, travel to local, state and regional MFP-related meetings, outreach forums, training sessions, and data collection.

Therefore, 100 percent federal funding is requested for grant-related travel. The total travel cost for CY 2011 is \$25,000. The total cost over the life of the demonstration is \$150,000.

f. Supplies

Costs for supplies built in for each year include paper, printing, telephone, postage and other miscellaneous supplies related to the MFP demonstration. Therefore, 100 percent federal

funding is requested for MFP-related supplies. The total supply cost for CY 2011 is \$7,000. The total cost over the life of the demonstration is \$42,000.

g. Equipment

The cost for one new computer per employee is built in budget Year 1. Vermont will also invest in a critical incident database reporting system in Year 1. One hundred percent (100 percent) federal funding is requested for this equipment since it will be used solely for the MFP program. The total equipment cost for CY 2011 is \$20,000.

h. Other Costs

Other costs include training, marketing and outreach materials, rental space for training and outreach forums, translation, broadcasting, and MFP website hosting and development fees. Since the expenses are directly for the MFP program, Vermont is requesting 100 percent federal funding for "other" cost items. The total cost for "other costs" for CY 2011 is \$84,000. The total cost over the life of the demonstration is \$359,000.

Per Capita Costs

The average per participant for service costs associated with this demonstration is \$45,504. The average per participant for administrative costs associated with this demonstration is \$10,236.

Deleted: 3,212

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The average per participant for Quality of Life assessment costs associated with this demonstration is \$100.

3. Evaluation Budget: Please include annual estimated costs of the evaluation activities the State is proposing.

Vermont contracts with the University of Massachusetts to conduct the independent evaluation of the Choices for Care waiver. The state may ask the University to undertake evaluation activities related to the MFP demonstration sometime in the future. However, the state at this time is not proposing to conduct an independent evaluation of the demonstration. Vermont will fully support the national evaluator in accordance with grant requirements.

Please refer to Appendix J for the Required Maintenance of Effort Forms and to Appendix K for the Required Sub Appendix IV - Worksheet for Proposed Budget Form.

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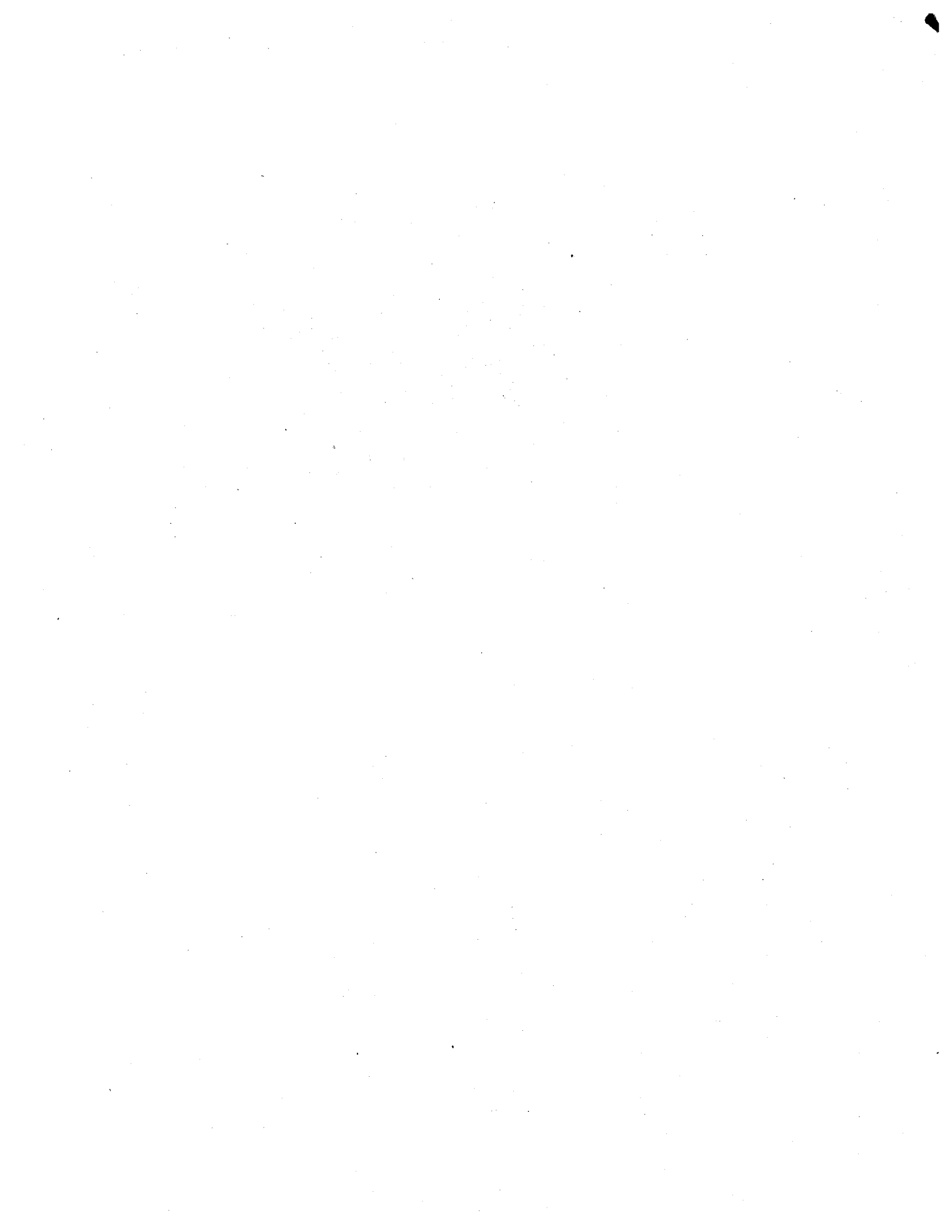
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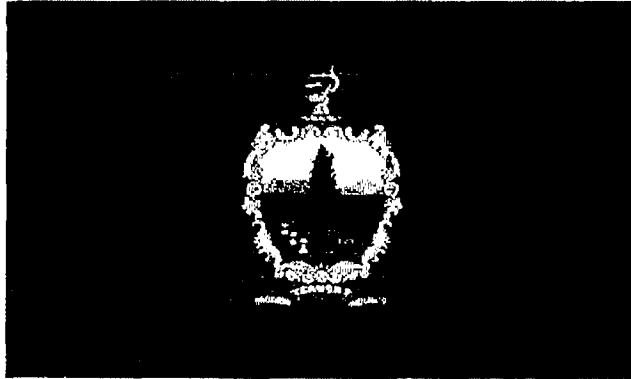
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3/28/2011 4:06:00 PM

Transition X Consultants	Contracted	3/1/11	5/15/11
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The Vermont
Money Follows the Person Rebalancing Demonstration
Appendices



Submitted by:

State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living

January 7, 2011

CFDA 93.791

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-- Vermont Center for Independent Living

-- Community of Vermont Elders

-- DAIL Advisory Board

-- Vermont Association of Area Agencies on Aging

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APPENDIX A
CHOICES FOR CARE EMPLOYER HANDBOOK FOR SELF DIRECTION

Choices for Care
Vermont Long-Term Care Medicaid

Employer Handbook
Consumer and Surrogate Directed Services

Revised July 2009

This information is important. If you do not understand it, take it to your local office for help.

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour recevoir de l'aide. **French**

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

Thông tin này rất quan trọng. Nếu quý và không hiểu nội dung trong này, hãy đem thư này đến văn phòng tại địa phương của quý và nhờ đồng nghiệp giúp đỡ.
Vietnamese

Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
Division of Disability and Aging Services
103 South Main Street – Weeks 2
Waterbury, Vermont 05671-1601
802-241-1228 (voice/ttd)
www.dail.state.vt.us

Payroll Agent:
ARIS Solutions
P.O. BOX 4409
White River Junction, VT 05001
1-800-798-1658

This document is available in alternative format upon request.

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CHAPTER I: Introduction

The Vermont Department of Disabilities, Aging and Independent Living (DAIL) manages the Choices for Care (CFC) program. The goal of this program is to offer eligible elders and adults with physical disabilities a choice of long-term care services in the setting they choose.

In the Home-Based setting, the CFC program offers three services that may be directed by the individual (consumer-directed) or a surrogate employer. These services include:

- Personal Care
- Respite Care
- Companion Services

Being an **EMPLOYER** is a big responsibility and should not be taken lightly. If an individual who is participating in the CFC program is able and willing to be an **EMPLOYER** for their own Personal Care, Respite or Companion services, they may apply for the consumer-directed option. However, if the individual is not able or willing to be the employer, a trusted friend or family member may apply to be the surrogate-directed **EMPLOYER**.

Whether consumer or surrogate directed, the CFC case manager must certify that the individual or surrogate is eligible to be the **EMPLOYER**. Once certified, the **EMPLOYER** agrees to perform all activities required to hire, train, and supervise personal care attendants, respite and/or companion employees. This manual will help **EMPLOYERS** understand their responsibilities as well as the CFC program requirements.

CHAPTER II: Eligibility

1. Program Eligibility

To be eligible for the Choices for Care (CFC) program, an individual must:

- a) be a Vermont resident;
- b) be at least 65 years of age, or 18 or older and have a physical disability;
- c) be financially eligible for Long-Term Care Medicaid;
- d) meet the clinical criteria;
- g) make an informed choice to accept CFC services in a Service Plan.

Individuals who wish to direct their own services must also meet the following **EMPLOYER** eligibility guidelines.

2. Employer Eligibility

The CFC case manager must certify that any individual or surrogate who wishes to be an **EMPLOYER** of services. As a part of this process the case manager will complete an "Employer Certification Form".

All consumer or surrogate-directed **EMPLOYERS** must have the cognitive ability to communicate effectively and perform the activities required of an employer. Cognition and communication are defined as follows:

- a. **Cognition:** the ability to understand and perform the tasks required to employ a caregiver (including recruitment, hiring, scheduling, training, supervision, and termination). An individual who has cognitive impairments or dementia that prevent understanding and performance of these tasks, is not competent, or has a guardian, is not eligible to manage waiver services.
- b. **Communication:** the ability to communicate effectively with the case manager and with the caregiver(s) in performing the tasks required to employ a caregiver. An individual, who cannot communicate effectively, whether through verbal communication or alternate methods, is not eligible to manage waiver services.

In addition, the **EMPLOYER** must live within close proximity to the individual in order to monitor services and supervise employees adequately. Employers must demonstrate over time that they have the ability to understand program rules and to reliably perform employer responsibilities. If the individual or surrogate is not able or willing to be the **EMPLOYER**, the case manager will discuss other options.

CHAPTER III: Program Limitations

The Choices for Care (CFC) program has the following limitations under the consumer or surrogate directed option:

1. Consumer and surrogate employers are **not** paid by the CFC to direct and manage services.
2. An individual's legal guardian (appointed by a probate court) may **not** be paid to provide services under CFC.
3. An employee who is paid by CFC to provide services for the individual may **not** also serve as the surrogate employer.
4. Employees must be 18 years of age or older.
5. CFC only provides services and care for the individual who has been found eligible. Therefore, services are **restricted to the benefit of the individual**.
6. Persons with any of the following may not be paid to provide services under the CFC program (*DAIL Background Check Policy, July 1, 2009*):
 - a. a substantiated history of abuse, neglect, or exploitation of an adult or child;
 - b. exclusion from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; or
 - c. a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust.
7. An individual's spouse or civil union partner may **not** be paid to provide companion services or respite services under the CFC program.
8. An individual's spouse or civil union partner may **not** be paid to provide personal care assistance with Instrumental Activities of Daily Living such as meal prep, medication management, phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.
9. Employees are not paid to provide services while the individual is admitted to a hospital or nursing facility.
10. Individuals may remain eligible for CFC up to **30 days** while absent from the state of Vermont.

APPENDIX A

11. Individuals may use their CFC services up to **7 days** while absent from the state of Vermont.
12. Surrogate employers shall not be certified to manage CFC services for more than two (2) individuals at one time.
13. CFC shall not be used to provide services that are otherwise being purchased privately or through another funding source.

CHAPTER IV: Service Descriptions

Choices for Care (CFC) covers the following consumer and surrogate-directed services in the Home-Based setting.

1. Personal Care Services

Personal Care Services may include help with the following:

- Dressing
- Bathing
- Grooming (help with brushing teeth, shaving, hair and skin care)
- Bed mobility (moving about while in bed)
- Toilet use
- Personal hygiene and clean up related to incontinence
- Assistance with adaptive devices
- Transferring (help getting to and from chair and bed)
- Mobility (help with walking or using a wheelchair)
- Eating

When needed, services may also include the following **for the individual only**:

- Help using the telephone
- Preparing meals
- Heavy housekeeping: for example, mopping floors and taking out garbage
- Light housekeeping: for example, changing the bed, dusting, vacuuming and doing laundry
- Shopping
- Travel assistance necessary for the person's health and welfare
- Care of adaptive equipment

The case manager together with the participant completes a “**Personal Care Worksheet**” and “**Service Plan**”. The case manager will provide the **EMPLOYER** with a copy of the Personal Care Worksheet. The Personal Care Worksheet describes the specific tasks and services that shall be provided for the individual. The Service Plan identifies the overall type and amount of services the individual has been approved to receive. The Personal Care Worksheet and Service Plan shall be used by the **EMPLOYER** to plan service schedules and approve timesheets.

2. Respite Care Services

Respite Care services are designed to provide a break or relief from care to the individual's primary, unpaid caregiver (e.g. spouse). Respite Care services are based on blocks of time, rather than on specific tasks. Respite Care may include supervision as well as the specific tasks described under Personal Care services. Only individuals who have an unpaid primary caregiver are eligible to receive Respite Care services. A maximum of **720 hours a calendar year** is available. If the individual also receives Companion services, the combined total may not exceed 720 hours a calendar year.

3. Companion Services

Companion services include non-medical care, supervision and socialization. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities on an ongoing basis. A maximum of **720 hours a calendar year** is available. If the individual also receives Respite Care services, the combined total may not exceed 720 hours a calendar year.

CHAPTER V: Employer Responsibilities

1. Employer Responsibilities

The Choices for Care (CFC) consumer and surrogate directed services are a wonderful option for many people. However, this option is not suited for everyone. Being an **EMPLOYER** is an important responsibility and should not be taken lightly. Please consider the following responsibilities before enrolling as an **EMPLOYER**.

The consumer or surrogate **EMPLOYER** must agree to perform the following ongoing tasks:

- ◆ Understand and follow program requirements
- ◆ Recruit and select qualified employee(s) that are 18 years of age or older
- ◆ Interview applicants and carefully check references before you offer anyone employment
- ◆ Notify selected employee(s) of their responsibilities
- ◆ Assure that employment forms are completed and submitted to the payroll agent (See Chapter VIII)
- ◆ Train employee(s) to perform specific tasks as needed
- ◆ Develop a work schedule based on the approved Service Plan
- ◆ Maintain updated copies of approved waiver Service Plan
- ◆ Arrange for substitute or back-up employees as needed
- ◆ Develop and maintain a list of tasks for the employee(s) to perform based on the Personal Care Worksheet
- ◆ Authorize employee(s) timesheets (based on the approved Service Plan and actual time worked)
- ◆ Maintain copies of all employee(s) timesheets
- ◆ Perform supervisory visits in the home of the individual at least once every thirty (30) days in order to assure that tasks are performed by the employee correctly and completely
- ◆ Evaluate employee(s) performance
- ◆ Provide ongoing performance feedback to employee(s)
- ◆ Terminate employee(s) employment when necessary
- ◆ Notify the payroll agent of any necessary changes
- ◆ Participate in the assessment and reassessment of CFC eligibility
- ◆ Communicate with the case manager on a regular basis (See Chapter IX.)
- ◆ If applicable, assure a monthly patient share is paid to the payroll agent (See Chapter VIII.)
- ◆ Track use of Respite and Companion service hours, so as not to exceed 720 hours a calendar year (See Chapter IV)
- ◆ Avoid conflict of interest with employees, the individual and/or other participating agencies

NOTE: Surrogate employers must live in close proximity to the individual and be available to perform the above employer responsibilities on an ongoing basis.

2. How to Find and Keep a Caregiver

EMPLOYERS may refer to the “**Help at Home: A Guide to Finding and Keeping Your Caregiver**” (published by Homeshare Vermont, Burlington, VT), for helpful information and tips on hiring, training and keeping caregivers/workers. **EMPLOYERS** may obtain a guide by contacting the Choices for Care case manager or Homeshare Vermont at (802) 863-5625 or <http://www.homesharevermont.org/>.

CHAPTER VI: How to Apply and Enroll

Once an applicant has been enrolled in Choices for Care (CFC), a case manager will assess their needs and assist the applicant through the process. The following outlines the steps involved with certifying **EMPLOYERS**, enrolling **EMPLOYERS** and **EMPLOYEES**.

1. Certification of Employer Eligibility

All consumer or surrogate directed **EMPLOYERS** must be certified as able and willing to direct Choices for Care services. Surrogate employers must live in close proximity to the individual and be available to perform the employer responsibilities on an ongoing basis.

a. Certification

During the initial assessment process, the case manager completes an “Employer Certification Form”. The case manager must verify and document that the prospective consumer or surrogate employer is able (as described under “Eligibility”) and willing to direct and manage services. By signing the Service Plan and Employer Agreement form the **EMPLOYER** agrees to perform the required activities. The case manager will continue to monitor the employer’s ongoing eligibility during monthly contact and annual reassessments.

b. Non-Certification

If the case manager determines that the consumer or surrogate is not able to perform the ongoing tasks required as the **EMPLOYER**, the individual shall be notified of the decision in writing. The notice will include appeal rights.

2. Enrolling Employers

Once certified, all consumer and surrogate directed **EMPLOYERS** must enroll in the payroll system as described below:

- a. **Contact Payroll Agency:** Certified **EMPLOYERS** must contact the following payroll agent to obtain the necessary forms to become enrolled in the payroll system:

ARIS Solutions
P.O. BOX 4409
White River Junction, VT 05001
1-800-798-1658

b. EMPLOYER Forms: The following forms must be completed by the **EMPLOYER** and returned to the payroll agent in order to enroll in the payroll system:

- Form 2678 Employer Appointment of Agent Form (IRS # 2678)
- Consumer/Surrogate Directed Employer Agreement Form
- Worker's Compensation Authorization Form
- Power of Attorney Form
- Consumer Information Form

Important: *Timesheets cannot be processed, nor can payments to workers be made, until ARIS has an approved Service Plan and all of these forms have been received and processed by the payroll agent.*

3. Enrolling Employees

Once the employer has located a suitable **EMPLOYEE(S)**, the **EMPLOYEE** must complete the following forms and return to the payroll agent. **This applies to both new employees and returning employees who have not been employed by the consumer in the current calendar year:**

- Form W-4 Employee's Withholding Allowance Certificate
- Form I-9 Employment Eligibility Verification Form
- Record Check Release Form Vermont Criminal Information Center
- Consent for Release of Information Adult Protective Services
- Background Check Release Form
- Optional: Form W-5 Earned Income Credit Advance Payment Certificate
- Optional: Direct Deposit Form

Important: *Timesheets cannot be processed, nor can payments to workers be made, until ARIS has an approved Service Plan and all of these forms (not including optional forms) have been received and processed by the payroll agent.*

EMPLOYERS should notify their employees that there may be a delay of several weeks before the first paycheck is issued. **EMPLOYERS** may wish to discuss this issue with the CFC case manager, as well.

CHAPTER VII: Employee Eligibility and Restrictions

1. Employee Eligibility

All **EMPLOYEES** must be legally eligible for employment under state and federal laws. In addition, for the Long-Term Care Medicaid (CFC) program, eligible **EMPLOYEES** must:

- be aged 18 years old or over, and
- be able and willing to perform required tasks, and
- be legally eligible to work in the state of Vermont
- Must not have a history of a substantiation of child or adult abuse, neglect or exploitation, a conviction of a violent crime, money crime or felony drug offence or any other conviction as indicated on the State of Vermont Background Check policy

On a case-by-case basis, the Department of Disabilities, Aging and Independent Living (DAIL) may approve an employee under the age of 18 to provide services when the employee has the experience and skills specific to working with elders with functional limitations or individuals with disabilities. Requests must be presented in writing to DAIL.

2. Employee Restrictions

There are some important program limitations that apply to all Employees. Please read **Chapter III. Program Limitations** carefully.

CHAPTER VIII: Payroll Policies and Procedures

1. Payroll Agent

Payroll services are provided by the Choices for Care (CFC) program, through a contracted payroll agency. The payroll agent will process timesheets, paychecks and taxes, maintain employment tax records for employees and perform related payroll activities, including background checks for substantiated incidents of abuse, neglect, or exploitation of others and for criminal records.

The payroll agent for the CFC is:

ARIS Solutions
P.O. BOX 4409
White River Junction, VT 05001
1-800-798-1658

The payroll agent will provide employers and employees with:

- All of the necessary employment forms,
- Timesheet forms,
- Pre-stamped addressed envelopes for mailing timesheets to the payroll agent,
- Annual W-2 tax statements to employees
- Instructions and technical assistance in completing forms

2. Submitting Timesheets

All employee timesheets must be submitted in the following manner:

- The timesheet must be completed correctly, including the dates and times of service.
- The employer must sign the timesheet to verify that services were received.
- The timesheet must be completed correctly, and legibly, including the signatures of both the employee and the employer.
- The timesheet must be submitted to the payroll agent according to the payroll schedule (See appendix).
- **NOTE:** ARIS will not accept **FAXED** timesheets.

Important: *Neither DAIL nor the payroll agent are responsible for delays in payment caused by sending in late timesheets, incomplete or illegible forms, or neglect of the EMPLOYER or EMPLOYEE to inform the payroll agent of changes in address, etc.*

3. Additional Employees or Replacement of Employees

All new **EMPLOYEES** must complete the employment enrollment process before receiving any paychecks. There are no exceptions to this policy.

4. Termination of Employment

The **EMPLOYER** is responsible for termination of employment, and for notifying the case manager and the payroll agent of all changes in the employment status of **EMPLOYEES**. The **EMPLOYER** must complete an "Employee Action Notice" form and submit to ARIS each time an **EMPLOYEE** terminates employment.

5. Instructions for Completing Timesheets

All timesheets shall be completed with the following information. **All items must be legible!**

- Print **EMPLOYEE** name and social security number on the top corner of timesheet.
- Print the waiver participants name under "consumer" at the top of the timesheet.
- Print the surrogate **EMPLOYER'S** name, if applicable, under "surrogate" at the top of the timesheet.
- Print the last day of the pay period under "Pay Period End Date". (refer to payroll schedule if needed)
- Enter the date worked in the "Date" column.
- Enter the daily work start time in the "In" column and work stop time in the "Out" column. **Note: If the employee lives with the waiver participant, they may write "Live-in" in place of "in" and "out" times.**
- Enter the total hours of Personal Care worked in decimal format (in 15-minute units) in the "Personal Care Hours" column for each day worked.
- Enter the total hours of Respite Care worked in decimal format (in 15-minute units) in the "Personal Care Hours" column for each day worked.
- Enter the total hours of Companion Care worked in decimal format (in 15-minute units) in the "Personal Care Hours" column for each day worked.
- Add the total Personal Care hours worked for week one and week two. Write the total hours in the "Personal Care Hours" box next to "Total Hours per Service for this Pay Period".

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- Add the total Respite Care hours worked for week one and week two. Write the total hours in the “Respite Care Hours” box next to “Total Hours per Service for this Pay Period”.
- Add the total Companion Care hours worked for week one and week two. Write the total hours in the “Companion Care Hours” box next to “Total Hours per Service for this Pay Period”.
- The **EMPLOYEE** must sign and date at the bottom above “Employee Signature” and “Date”.
- The **EMPLOYER** must sign and date the bottom above “Consumer/Surrogate Signature” and “Date”.

Example of hours entered in decimal format:

one hour: 1.0

two hours: 2.0

two hours and 15 minutes: 2.25

three hours and 30 minutes: 3.5

three hours and 45 minutes: 3.75

6. Approved Service

The total number of hours for *all employees combined* must **not** exceed the authorized number of hours for any services as shown on the individual’s approved Service Plan.

7. Changes in Hours

The **EMPLOYER** should contact the case manager directly to review the need for changes in approved services. A written Service Plan change must be submitted and approved by DAIL **before** any increased service hours will be paid. **Approved changes will be effective the next payroll period after the request is received at DAIL, starting on a Sunday.**

8. Mailing Timesheets

Mail the timesheet to the payroll agent at the address at the bottom of the timesheet. The timesheet must be mailed to the payroll agent so that it reaches the payroll agent’s office by Monday morning following the end of a pay period.

If more than one **EMPLOYEE** works for a participant during the same pay period, the **EMPLOYER** must submit all employee timesheets for this pay period to the payroll agent at the same time.

9. Timesheet Errors

On occasion it may be necessary for ARIS to return timesheets to **EMPLOYERS**. This may result in employee's paychecks being delayed. ARIS is unable to process *any* timesheet that does not have the original signatures of both the **EMPLOYER** and the **EMPLOYEE**. Timesheets will be returned to the employer when the following information is missing or incorrect:

1. Absence of employee name
2. Absence of consumer name
3. Absence of employee signature
4. Absence of employer signature
5. Signature of anyone other than the employer of record on the employer signature line.
6. Absence of dates of service.
7. Two consumers listed for services on one timesheet. Employees must fill out one time sheet per pay period for each consumer they provide care for.

Should a timesheet be returned to the **EMPLOYER** for one of the above reasons, the **EMPLOYER** must complete or correct the identified error, and re-submit the timesheet to ARIS. The timesheet will be processed and paid in the next pay period following receipt in the ARIS Office.

10. Other Reasons an Employee may not get Paid

Other reasons an **EMPLOYEE** may not get paid:

1. Late time sheets. Time sheets must be received in the ARIS office **no later than Monday** of each pay week, according to the Payroll Schedule.
2. Lack of, or incomplete Employer enrollment forms.
3. Lack of, or incomplete Employee enrollment forms.
4. Lack of patient share payment (when a patient share has been determined)
5. Lack of a Department of Disabilities, Aging and Independent Living (DAIL) authorized Service Plan

11. Pay Schedule

Paychecks will be generated by the payroll agent every two (2) weeks, according to the payroll schedule.

12. Pay Rate

As of **July 12, 2009** **EMPLOYEES** who are paid through Consumer or Surrogate Directed Services option will be paid:

- \$10.14/hour Personal Care Services
- \$8.62/hour for Respite Care Services
- \$8.62/hour for Companion Services

Note: Workers are **not** paid overtime wages or benefits. The Medicaid rate identified on the Service Plan is higher than the **EMPLOYEE'S** wages because it includes worker's compensation and unemployment insurance that is covered by the state.

13. Patient Share

Under Long-Term Care Medicaid financial eligibility rules, some individuals must pay a monthly patient share payment to cover some of the costs of services. The amount of the patient share, if any, is determined by the Department for Children and Families (DCF). DCF will send a written notice to the individual explaining the amount (if any) of the required patient share. If the individual has a patient share, then:

- The patient share must be paid directly to ARIS each month in the amount indicated on the DCF notice of decision.
- The **EMPLOYER** must pay the monthly patient share in full with the timesheet of the first pay period of the month.
- Timesheets will not be processed, nor can payments to **EMPLOYEES** be made, unless the required patient share payment is submitted to the payroll agent.
- If the required patient share payment is not submitted to the payroll agent, the participant may be terminated from Consumer/Surrogate Directed Services.

Questions regarding Patient Share:

If there are questions about the **amount** of a patient share, contact the CFC case manager or the local District Office of the Department for Children and Families (see Appendix A).

14. Unemployment Benefits

Every **EMPLOYEE** is eligible for unemployment benefits if work hours become unavailable or decrease. If you have questions about unemployment compensation coverage, or about submitting a claim, contact the payroll agent.

15. Workers' Compensation

Every **EMPLOYEE** is covered by workers' compensation insurance. If you have questions about workers' compensation coverage, or about submitting a claim, contact the payroll agent.

16. Taxes

Payments made to every **EMPLOYEE** are treated as earned income, and are taxed as earned income. The payroll agent processes payroll taxes, withholds taxes from wages and prepares annual W-2 tax withholding statements.

17. Problems with the Payroll Agent

EMPLOYERS and **EMPLOYEES** should first attempt to resolve payroll problems by directly contacting the payroll agent. If problems can not be solved, the **EMPLOYER** or **EMPLOYEE** may contact the case manager for assistance. Finally, if problems are still not solved with the help of the case manager, contact DAIL at (802) 241-1228.

18. Medicaid Fraud

Medicaid fraud is committed when an **EMPLOYER** or **EMPLOYEE** is untruthful regarding Choices for Care (CFC) services provided, in order to obtain improper payment. The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit fraud against the CFC program. Medicaid fraud is a felony and conviction can lead to substantial penalties (including but not limited to, imprisonment up to ten years, or a fine up to \$1,000 or an amount equal to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be excluded for a minimum of five years from any employment with a program or facility receiving Medicaid funding.

APPENDIX A

Examples of Medicaid fraud include:

- Submitting timesheets for services not actually provided (e.g. signing or submitting a timesheet for services which were not actually provided)
- Submitting timesheets for services provided by a different person (e.g. signing or submitting a timesheet for services provided by a different person)
- Submitting twice for the same service (e.g. signing or submitting a timesheet for services which were reimbursed by another source, or signing or submitting a duplicate timesheet for reimbursement from the same source)

Suspected cases of fraud will be referred to the Attorney General's Medicaid Fraud Control Unit and may be referred to the local police authorities for further investigation and possible prosecution.

CHAPTER IX: Case Management Services

Case Management services are provided to all individuals receiving Choices for Care (CFC) in the home-based setting. The case manager is responsible for certifying **EMPLOYERS** and monitoring the services and the health and welfare of individuals participating on the CFC program.

1. Case Manager Responsibilities

The case manager must visit the individual on a regular basis, not less than once every 30 days.

Case managers are responsible for:

- Answering questions about the CFC program
- Assisting individuals in gaining access to needed services
- Overseeing the assessment and reassessment of the individual
- Developing a service plan for the individual
- Monitoring the services included in an individual's service plan
- Assessing the adequacy of care being provided
- Certifying the ability of a consumer or surrogate employer to manage services
- Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services (see Chapter X)
- Reporting suspected cases of Medicaid Fraud to the State (see Chapter VIII)

2. Case Manager Limitations

Case Managers are **not** responsible for:

- Completing or processing payroll forms
- Payroll documentation and submission
- Hiring, firing and training employees

An individual's case manager can provide some *advisory* assistance with these activities, but the **EMPLOYER** is ultimately responsible for all employment issues concerning the **EMPLOYEES**.

CHAPTER X: Abuse, Neglect, and Exploitation

The State of Vermont requires, by law (Title 33, VT Statue), that all health professionals report cases of suspected adult abuse, neglect, and exploitation. Those who are “mandated” to report such cases include, but are not limited to:

- Case Managers,
- Personal Care Attendants,
- Respite Care Workers,
- Companion Workers,
- Home Health Agency Employees,
- Adult Day Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- Payroll Agent (ARIS)

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation. In most cases, the identity of the individual making the report shall remain confidential.

Reports are made by contacting the Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, Adult Protective Services (APS) at 1-800-564-1612.

APPENDIX A

Appendix: Local Agencies

1. Department of Disabilities, Aging and Independent Living

District Office	Phone	Fax
Barre	(802) 476-1646	(802) 476-1654
Bennington	(802) 447-2850	(802) 447-6972
Brattleboro	(802) 251-2118	(802) 254-6394
Burlington	(802) 879-5904	(802) 879-5620
Hartford	(802) 296-5592	(802) 295-4148
Middlebury	(802) 388-5730	(802) 388-4637
Morrisville	(802) 888-0510	(802) 888-0536
Newport	(802) 334-3910	(802) 334-3386
Rutland	(802) 786-5971	(802) 786-5882
Springfield	(802) 885-8875	(802) 885-8879
St. Albans	(802) 524-7913	(802) 527-4078
St. Johnsbury	(802) 748-8361	(802) 751-2644
Waterbury Central Office	(802) 241-1228	(802) 241-4224

2. Local Area Agencies on Aging

Champlain Valley Agency on Aging	(802) 865-0360
Northeastern VT Area Agency on Aging	(802) 748-5182
Central VT Council on Aging	(802) 479-0531
Southwestern VT Council on Aging: Bennington Rutland	(802) 442-5436 (802) 786-5991
Southeastern VT Council on Aging	(802) 885-2655

3. Local Home Health Agencies

Addison County Home Health & Hospice	(802) 388-7259
Bennington Area Home Health	(802) 442-5502
Caledonia Home Health	(802) 748-8116
Central VT Home Health	(802) 223-1878
Chittenden / Grand Isle Visiting Nurse Association	(802) 658-1900 (TDD) or (800) 833-6111
Franklin County Home Health Agency	(802) 527-7531
Lamoille Home Health	(802) 888-4651
Manchester Health Services	(802) 362-2126
Orleans / Essex Visiting Nurse Association	(802) 334-5213
Rutland Area Visiting Nurse Association	(802) 775-0568
Visiting Nurse Alliance of VT & NH	(800) 858-1696

APPENDIX A

4. DCF District Offices (Financial Eligibility)

Barre	(802) 479-1041 or 800 499-0113
Bennington	(802) 442-8541 or 800 775-0527
Brattleboro	(802) 257-2820 or 800 775-0515
Burlington	(802) 863-7365 or 800 775-0506
Hartford	(802) 295-8855 or 800 775-0507
Middlebury	(802) 388-3146 or 800 244-2035
Newport	(802) 334-6504 or 800 775-0526
Rutland	(802) 786-5800 or 800 775-0516
Springfield	(802) 886-3551 or 800 589-5775
St. Albans	(802) 524-7900 or 800 660-4513
St. Johnsbury	(802) 748-5193 or 800 775-0514

APPENDIX B
DRAFT MDS 3.0 SECTION Q PROTOCOL AND REFERRAL FORM

Vermont ADRC Proposal for Implementing “Nursing Home Transitions” Section Q of the MDS 3.0

Context:

Important progress has been made in the last 20 years so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. Legislation such as the Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999) have led to outcomes from various long-term care rebalancing initiatives, including grant and demonstration programs funded by CMS.

On October 1, 2010, changes to the MDS 2.0 will be implemented per CMS requirements. The new MDS 3.0 will become the new assessment tool used in all nursing facilities, including significant changes to Section Q. What does Section Q do?

- Broadens the traditional definition of “discharge planning” in nursing homes.
- Recognizes that an expansive range of community-based supports and services are necessary for successful community-living.
- Encourages nursing home interdisciplinary staff to assess long stay residents who may not have been previously considered as candidates for community living.
- Facilitates resident and nursing facility connection and communication with local contact agency experts to assess community resource availability and determine whether community discharge is possible.
- Meaningfully engages residents in their discharge planning goals.
- Directly asks the resident if they want information about long-term care community options.
- Promotes linkages and information exchange between nursing homes, local contact agencies, and community-based long-term care providers.
- Promotes discharge planning collaboration between nursing homes and local contact agencies for residents who may require medical and supportive services to return to the community.

New Expectations:

- The appropriate State agency (in VT, DLP) is expected to identify “Local Contact Agencies”.
- Nursing home staff are expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.
- Local Contact Agencies are expected to respond to nursing home staff referrals by providing information to residents about available community-based long-term care supports and services.
- Nursing home staff and Local Contact Agencies are expected to meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long-term care services.
- State Medicaid Agencies will have to amend their Data Use Agreement (DUA) with CMS to share MDS data with the organization(s) that they create agreements with and designate to provide information to individuals about community and HCBS options. A DUA is not required to refer a resident to speak to someone about return to community.

Implementation Strategy:

- The statewide Aging and Disability Resource Connection (ADRC) will serve as the umbrella coordinator for the Local Contact Agencies (LCAs)
- The following ADRC partner agencies are identified as the LCAs:
 - 5 Area Agencies on Aging
 - Vermont Center for Independent Living
 - Brain Injury Association of Vermont
- Procedural Operations and Flow Chart (next page)

1) Initial Referral

Nursing facility, through Section Q, identifies individual wanting to speak with someone about the possibility of returning to the community

- a. Individual age 60 or over $\xrightarrow{\text{Referred to}}$ Area Agency on Aging via Senior Helpline ---
1-800- 642-5119
 - i. For calls coming to CVAA as the default for out-of-state referrals:
 1. CVAA will determine where individual resides and will make referral to appropriate AAA, VCIL, or BIAVT based upon answers to standard basic questions below
- b. Individual under age 60 $\xrightarrow{\text{Referred to}}$ Vermont Center for Independent Living I-Line
1-800-639-1522
 - i. VCIL will make referral, as appropriate based upon answers to standards basic questions, to BIAVT or other agency to model “team approach” to follow up.
- c. CVAA and/or VCIL will ask nursing facility staff a series of questions to determine appropriate follow-up:
 - i. How is the individual’s stay in the NH being paid for? (Medicaid—if on Medicaid is on Choices for Care, Medicare, private insurance, private pay)
 - ii. Is the individual on Choices for Care? If yes....
 - iii. Does the individual already have a case manager associated with one of the partner agencies or a Home Health Agency? If yes....
 1. If the case manager is from a home health agency, referral to ADRC partner agency must also include involvement of HHA case manager in follow-up

2) Follow Up

Based upon answers to standard basic questions, CVAA and VCIL will make referral to any of the other ADRC partner agencies (other AAAs, VCIL or BIAVT) for follow up, and to the HHA case manager if the individual is on CFC and has a HHA case manager already identified.

- a. For border facilities (NH, MA, NY), the LCA (AAA, VCIL, or BIAVT) that serves that area will conduct the first follow up contact and determine whether the individual is truly a candidate for transition. If so, that agency will then refer the individual to the appropriate partner agency serving the town of residence where the individual resides or will return “home”.
- b. At a minimum, a phone contact is made with the individual to initiate a conversation about the possibility of returning to the community. *Per CMS, the designated LCA should follow up about the resident’s request within 10 business days of a yes response being given on Section Q. This is a recommendation however, and not a requirement. Follow-up is expected in a “reasonable” amount of time. We would expect a reasonable contact response time on the part of the LCA of within 3 days by phone and within 10 days if an on-site visit is needed. States may establish their own process to monitor performance.*
- c. *Per CMS, a referral to the LCA should be made if the resident wishes, even if they have a legal guardian, durable power of attorney for health care or a legally authorized representative, in accordance with state law.*
- d. LCA works with individual/surrogate/guardian/family and nursing facility to discuss options and build a transition plan, if it is feasible. *Per CMS, the level and type of response needed by an individual is determined on a resident-by-resident basis and is to be part of the State’s design for Section Q implementation.*
- e. *Per CMS, the skilled nursing facilities and nursing facilities and LCAs must explore community care options and conduct appropriate care planning together to develop an array of supports for assisting the resident if transition back to the community is possible.*
- f. If individual is on Choices for Care, once options are discussed and person chooses Choices for Care community options, involvement of LTCCC will facilitate logistics—choice of case manager, etc.
 - i. If individual is on Choices for Care, the appropriate LCA must determine if the individual has already selected a case manager. If so, that case manager must be informed and involved in the transition discussions.
- g. If individual is private pay, discussion and selection of options, and development of transition plan would occur with support of LCA.
- h. Of note—there may be instances where a “team approach” is the optimal approach. For example, an elder with a TBI. In these circumstances, the LCAs working collaboratively to assist the individual are desirable.

Outstanding Questions:

- 1) What should the role of ombudsmen be? See answer below from CMS Q&A:
The long-term care ombudsman is available to assist nursing home residents by resolving complaints related to the transitions process, as well as by providing information and education to consumers, facility staff, and the general public regarding the transitions process. However, the coordination of services is not a typical Ombudsman role. Possible major activities might include: 1) investigation and resolution of resident complaints about transitions to the community, 2) supporting residents in their decision-making related to transitions, 3) providing information to consumers and providers

(i.e. consultation to individuals) about residents rights and options, 4) providing educational sessions and materials to consumers and the general public about resident rights and options, and 5) Helping to identify candidates for transitioning to community living and making referrals as appropriate.

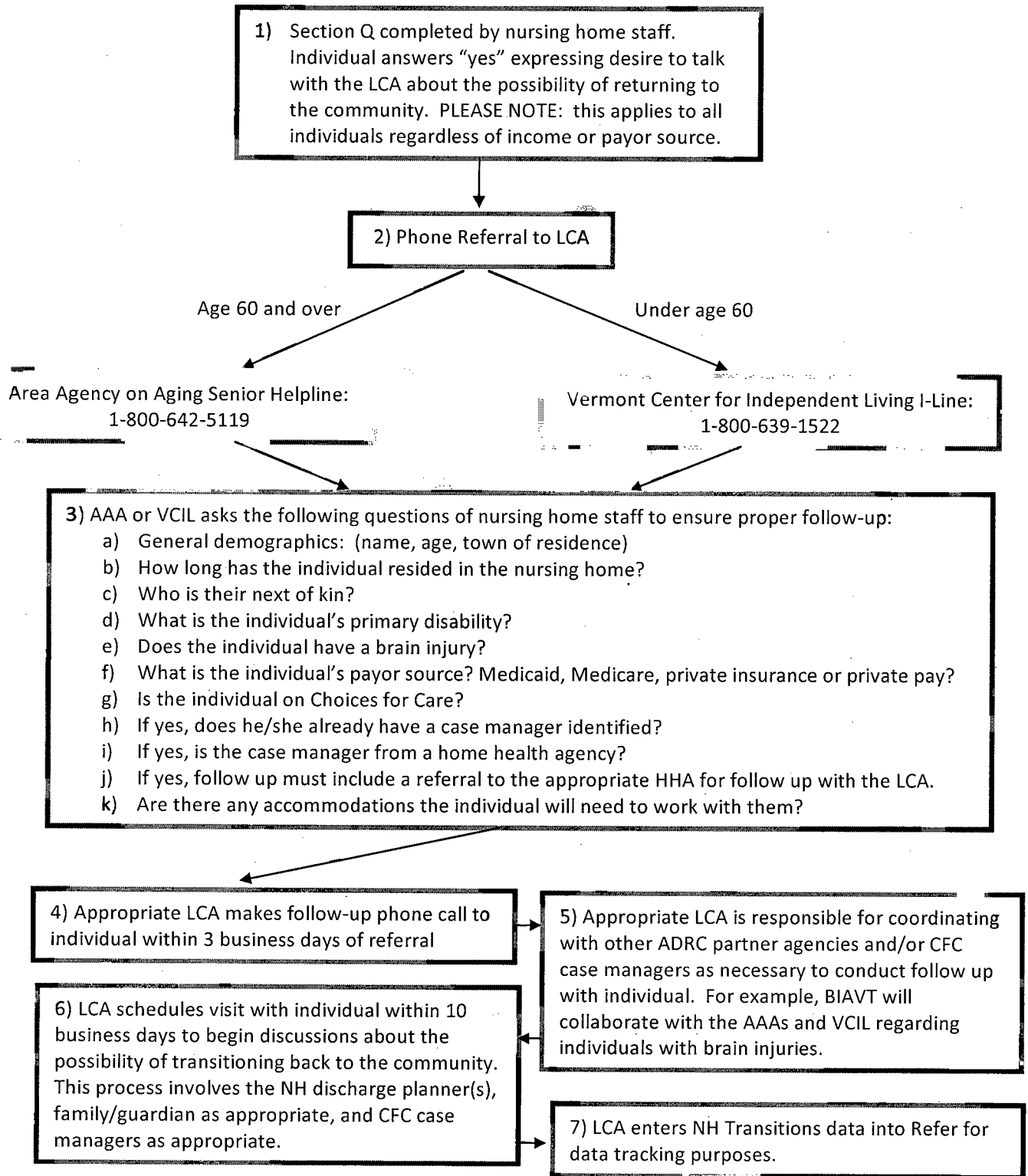
- 2) Who will ensure Data Use Agreement is in place and what information does it cover? See answer below from CMS Q&A:

In order for the local contact agencies to receive Minimum Data Set (MDS) data (i.e. a list of names of individuals from the MDS data set who answered, "Yes, I would like to speak to someone about the possibility of returning to the community" for each nursing facility), States will need a revised Data Use Agreement. CMS is asking State Medicaid agencies to amend their Medicaid MDS Data Use Agreements to include designated local contact/referral agencies if this is the case. The Medicaid Data Use Agreement must be amended to include those local contact agency entities to be authorized to obtain individual named referrals from the MDS data base in order to comply with the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) rule. This relationship must be included in the contract or memorandum of understanding between the Medicaid agency and the local contract agency (LCAs).

The Medicaid Agency's Data Use Agreement *applies to all nursing facility residents included in the MDS data base.*

See flow chart on next page.

“Nursing Home Transitions” Flowchart



APPENDIX B

**Agency of Human Services
Department of Disability, Aging and Independent Living**

State of Vermont

**Nursing Home
MDS 3.0 Section Q Referral**

Date of Referral

I. Nursing Home			
Name - Facility		Local Contact Agency (LCA) Name	
NF Staff Contact(s)		LCA Staff Contact(s)	
NF Phone Number		LCA Phone Number	
NF Fax Number		LCA Fax Number	
II. Resident Being Referred			
Name- Resident		Room Number	Date of Birth
Telephone Number to Reach Resident		County of Residence Prior to Admission	
<input type="checkbox"/> Yes <input type="checkbox"/> No Does this resident have a legal guardian?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Does this resident have an enacted Durable Power of Attorney			
Name – Legal Guardian/Enacted Durable Power of Attorney			Telephone Number
Individual's Payer Source (<i>Check all that apply</i>)			
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> PACE <input type="checkbox"/> Private Insurance <input type="checkbox"/> Private Pay <input type="checkbox"/> Other			
III. Authorized Representative (if applicable)			
Name-Representative		Telephone number	
Mailing Address- Street		City	State Zip Code
Individual's Preferred Contact: <input type="checkbox"/> Self <input type="checkbox"/> Other Name:		Relationship	
IV. Signature (Optional)			

Signature – Resident or Resident's Legal Representative

Date Signed

- Submit a completed copy of this form to the local contact agency (ADRCs) serving in the county in which the nursing home is located within ten (10) business days of completing Section Q of the MDS. Do NOT submit it to the resident's county or residence.
- Keep a copy of the referral form in the resident's medical record

APPENDIX C
CHOICES FOR CARE PARTICIPANT HANDBOOK

Choices for Care
Vermont Long-Term Care

Participant Handbook

June 2009



This information is important. If you do not understand it, take it to your local office for help.

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour recevoir de l'aide. **French**

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

Thông tin này rất quan trọng. Nếu quý vị không hiểu nội dung trong này, hãy đem thông này đến văn phòng tại địa phương của quý vị và nhờ đồng nghiệp giúp đỡ. **Vietnamese**

Vermont Agency of Human Services

Department of Disabilities, Aging and Independent Living

Division of Disability and Aging Services

103 South Main Street – Weeks 2

Waterbury, Vermont 05671-1601

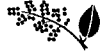
802-241-1228 (voice/ttd)

www.dail.vermont.gov

Your Case Manager or Program Contact: _____

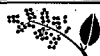
Phone: _____

This document is available in alternative format upon request.



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CHAPTER I: Introduction

Welcome! You have chosen the Vermont Choices for Care Medicaid Waiver (CFC) program to help provide your long-term care services. The Department of Disabilities, Aging and Independent Living (DAIL), Division of Disability and Aging Services (DDAS) manages the **Choices for Care** (CFC) program. It was created to help Vermont elders and adults with physical disabilities pay for long-term care services in the setting of their choice.

This Participant Handbook was created to:

- Help you understand the program,
- Help you understand your rights and responsibilities in the program,
- Help you understand provider rights and responsibilities,
- And help you know who to contact when you need assistance.

Where can you receive Choices for Care services?

1. In your home or the home of another person, or
2. In an approved Residential Care Home or Assisted Living Residence, or
3. In an approved Nursing Facility.

This Participant Handbook will tell you more about what is available and the limitations under each **Choices for Care** option.

Where can you get more information?

For more information about the **Choices for Care** program you may:

- Contact your case manager or program contact written on the front of this handbook.
- Contact the provider of your services or the local Long-Term Care Clinical Coordinator (LTCCC) listed in the back of this handbook.
- Contact a VT Long-Term Care Ombudsman listed in the back of this handbook.
- Contact the Division of Disability and Aging Services (DDAS) at (802) 241-1228 or find information online at <http://www.ddas.vermont.gov/>.
- For financial eligibility information, contact the Department for Children and Families (DCF), Economic Services Division (ESD) listed in the back of this handbook.



CHAPTER II: Eligibility

What are the eligibility criteria for Choices for Care?

To be eligible, you must:

- a) be a Vermont resident;
- b) be at least 18 years old (55 or older for the PACE option);
- c) meet the clinical criteria (nursing home level of care);
- d) be financially eligible for Vermont Long-Term Care Medicaid.

NOTE: Individuals who want to manage their own services at home must also meet all EMPLOYER eligibility guidelines.

Once you are on the program, your eligibility will be reviewed on a regular basis (at least once a year) to make sure you continue to meet all of the eligibility criteria.

What are the clinical eligibility criteria?

The clinical eligibility criteria for the Choices for Care program is the same as “**nursing home level of care**”. To make sure you meet these clinical criteria, a Long-Term Care Clinical Coordinator (LTCCC) nurse assesses your abilities and the help you need with things such as:

- Activities of Daily Living - how you manage day-to-day with activities like dressing, bathing, walking, and using the bathroom
- Cognition - how you remember and use information
- Medical conditions and treatments

Once you are on the program, your clinical eligibility will be reassessed at least once a year. If your health and care needs improve and you no longer need nursing home level of care, you will receive a notice letting you know you are no longer eligible for the program. The notice will also explain your appeal rights.

What is the financial eligibility criteria?

To be eligible for Choices for Care you must meet all Long-Term Care Medicaid financial criteria. To determine financial eligibility, your local Department for Children and Families (DCF), Economic Services Division (ESD) looks at your income, assets and whether you gave away assets such as money or real estate. While you are on the program, ESD will send you financial review forms once every 6-12 months. You must complete and return the review forms timely so ESD can review your eligibility for Long-Term Care Medicaid and continue your participation on the program. ***If you do not complete and return your review forms, your Medicaid eligibility will be closed and you will be terminated from the program, including all of your Choices for Care program services.***

APPENDIX C

If at any time you are found ineligible for Long-Term Care Medicaid, you will receive a notice from DCF. The notice will also explain your appeal rights.

NOTE: While you are on the program, you must report certain changes to DCF as described in your DCF financial eligibility notice.



CHAPTER III: Program Options

For more information and service limitations, go online to the Choices for Care Program Manual at <http://www.ddas.vermont.gov/>. These services are not intended to replace other Medicare, Medicaid or health insurance covered services you may already be receiving or are eligible to receive.

How can you receive care in your own home or the home of another person?

A. Home-Based Services:

If you would like to have a choice of multiple services while living in your own home or the home of another person, you may be interested in this option. The home-based option uses case management services to help you create a plan for services which is based on your abilities and needs. Case management services are provided by either your local Area Agency on Aging or approved Home Health Agency.

→ Services Include:

1. Case Management –assists in obtaining, coordinating and monitoring services
2. Personal Care –assists with activities of daily living such as dressing, toileting and transferring.
3. Adult Day – Adult Day centers provide meals, activities, nursing, personal care and supervision.
4. Respite – a break for your unpaid caregiver such as a family member.
5. Companion – read mail, write letters, play cards, social visits, etc.
6. Personal Emergency Response (PERS) – phone line button to call for help.
7. Assistive Devices/Home Modification – such as a ramp to your home or a reacher-grabber.

NOTE: The amount of Personal Care Services approved is based on your assessed unmet needs and is limited. Ask your case manager or LTCCC if you have any questions.

There are two ways to manage your home-based Personal Care, Respite Care and Companion Services. Your case manager can help you decide which option best fits your needs. They are:

1. **Agency Directed Services**: If you would like a home health agency to hire, supervise and manage your Personal Care, Respite and Companion Services, you may be interested in the Agency Directed option. With this option, scheduling of your care is based on the type of care that you need as identified in a service plan and the agency's availability of staff. If you have any questions or concerns regarding staffing of your care, please contact your local home health agency listed in the back of this handbook.

2. **Consumer/Surrogate Directed Services**: If you or a trusted person (surrogate) you know living nearby, are able and willing to hire, supervise and manage your own caregivers, you may be eligible under the Consumer or Surrogate Directed option. This option gives you more control over who you hire and how you schedule your care. You or your surrogate becomes the “employer”. Speak with your case manager if you are interested in this option.

- B. **Flexible Choices**: Flexible Choices is the home-based option that offers you the most flexibility and control of your care plan. While Flexible Choices expects a lot of you, it gives you the opportunity to design your care in the way that best meets your needs. To be eligible for this option, you must be able to supervise and manage your own care and services or have an eligible surrogate who can do it for you.

Flexible Choices approves a monthly **allowance**, which is based on your assessed needs. Working with a **Flexible Choices consultant**, you develop a **budget** for how you will spend that allowance in a way that best meets your needs. Case management services are only available if you decide to include it in your budget. However, if you chose to pay your spouse to provide personal care, you must include a certain amount of case management in your budget.

In your budget you can decide:

- **How much you want to pay** your caregivers,
- To **save up** unspent amounts from the allowance from week to week to use when you really need them,
- To **purchase things** to keep you healthy and independent,
- To have a **small amount of cash** to pay for things like shoveling your walk or paying for rides to the store.

NOTE: The amount of your approved Flexible Choices allowance is based on your assessed needs and is limited. Ask your Flexible Choices consultant or LTCCC if you have any questions.

- C. **Program for All Inclusive Care for the Elderly (PACE)**: PACE is a program that combines your Medicare and/or Medicaid benefit so that the PACE organization can arrange for and provide all of your health care services. The following additional eligibility criteria apply:

- You must be at least 55 years old ,
- You must live in one of the following areas:
 - Chittenden County or the towns of South Hero or Grand Isle.
 - Rutland County or the towns of Dorset, Rupert or Manchester.
- You must be able to live safely in the community with services from PACE.

You must agree to use the PACE physician as your primary physician.

→ The PACE benefit package includes, but is not limited to:

1. Interdisciplinary team assessment and treatment planning,
2. Primary care services including physician and nursing services,
3. Social work services,
4. Restorative therapies, including physical therapy, occupational therapy and speech-language pathology,
5. Medications delivered to your home,
6. Personal care and supportive services,
7. Nutritional counseling,
8. Recreational therapy,
9. Transportation to appointments,
10. Meals at the PACE site,
11. Medical specialty services,
12. Laboratory tests, x-rays and other diagnostic procedures,
13. Drugs and biologicals,
14. Prosthetics and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items,
15. Acute inpatient care,
16. Nursing facility care.

What services can you receive in a Residential Care Home or Assisted Living Residence?

If you would like to live in a Residential Care Home or Assisted Living Residence where you can receive care and supervision 24 hours per day, you may be interested in the “Enhanced Residential Care” (ERC) option. In ERC, Medicaid pays a daily rate to eligible VT Licensed Residential Care Homes and Assisted Living Residences to provide you with a package of services. You pay the home for your room and board. Case management services are also provided through your choices of the local Area Agency on Aging or approved Home Health Agency. A list of ERC providers can be found online at <http://www.dail.state.vt.us/lp/> or by calling (802) 241-2345.

→ Services include:

1. Nursing Overview & Assessment
2. Personal Care Service
3. Medication Management
4. Recreation Activities
5. 24-Hour On-Site Supervision
6. Laundry Services

7. Household Services
8. Documentation
9. Case Management Services (from the local Home Health Agency or Area Agency on Aging)

NOTE: You will be responsible to pay the ERC Provider for the cost of your room & board.

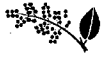
What services can you receive in a Nursing Facility?

If you would like to live in a Nursing Facility that provides a wide array of health, medical, therapeutic and personal care services 24 hours per day, you may be interested in the Nursing Facility option. This option pays a VT Licensed Nursing Facility a daily rate to provide you with a package of long-term care and skilled nursing/rehabilitation services. A list of nursing facilities can be found online at <http://www.dail.state.vt.us/lp/> or by calling (802) 241-2345.

→ Services include:

1. Room and Board
2. Skilled Nursing & Assessment
3. Personal Care
4. Medication Management and Pharmacy Services
5. Social Worker Services & Recreation Activities
6. 24-Hour On-Site Nursing Care and Supervision
7. Laundry Services
8. Housekeeping Services
9. Transportation Services
10. Physical Therapy, Occupational Therapy and Speech Therapy
11. Nutritional and Dietary Services
12. Maintenance of Resident Clinical Records

NOTE: Nursing facility services may also be available to you on a short-term basis to recover from an illness or injury, under your Medicare or other health insurance benefit.



CHAPTER IV: Program Limitations

There are some important program limitations that you should know about. If you need more information, please speak with your case manager, provider agency or go online to the Choices for Care program manual at: <http://www.ddas.vermont.gov/>.

What are the eligibility limitations?

1. Individuals whose need for services is due to mental retardation, autism, or mental illness are not eligible for Choices for Care.
2. Choices for Care will not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicare, Medicaid, Veterans health benefits, or another Medicaid Waiver program.
3. If your income is more than the Long-Term Care Medicaid income standard, you may have to pay some of the cost of your services every month. This is called a patient share. If you have a patient share, your notice from DCF/ESD will say how much it is and who to pay it to. Contact DCF if you have any questions about your patient share.

What are the program limitations?

All Choices for Care services are subject to certain limitations. Refer to the Program Manual or ask your case manager, provider of services or local LTCCC for detailed service limitations. Here is a list of important limitations that apply to all CFC services:

1. The Choices for Care regulations require that services be provided in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. In some cases, a Home-Based plan may be adjusted if the volume of care is deemed unnecessary or is being duplicated by another service.
2. CFC only provides services and care for the individual who has been found eligible. Therefore, services are **restricted to the benefit of the individual**.
3. CFC shall not be used to provide services that are otherwise being purchased privately or through another funding source.
4. CFC services shall not be furnished to individuals who are inpatients of a hospital facility for an acute medical stay (except in the PACE option which pays for all necessary health care services).
5. An individual's legal guardian (appointed by a probate court) shall not be paid to provide services under CFC.

6. Individuals who are absent from the state of Vermont for more than 30 days will be terminated from the program.
7. Individuals are not eligible to be on both Choices for Care in addition to another program that provides similar services, such as the Attendant Services Program, Hospice Program, the Developmental Services Waiver and the Traumatic Brain Injury program.
8. Persons with any of the following may not be paid to provide services under the CFC program (*DAIL Background Check Policy, April 1, 2006*):
 - a. a substantiated history of abuse, neglect, or exploitation of an adult or child;
 - b. exclusion from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; or
 - c. a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust.

What are some other limitations in the Home-Based option?

1. Case Management is limited to 48 hours per calendar year.
2. The amount of Personal Care Services is limited to the assessed need of the individual. The amount of approved hours is subject to review and approval by the Long-Term Care Clinical Coordinator.
3. Respite and companion services are limited to 720 hours per calendar year (total/combined).
4. Assistive device and home modifications are limited to \$750 per calendar year. Some items are automatically approved, some items need pre-authorization and some items are never allowed. Check with your case manager. If you are on Flexible Choices, check with your consultant about limitations for assistive devices and home modifications.
5. Your spouse can not be paid by CFC to provide assistance with any Instrumental Activities of Daily Living (meal prep, medication assistance, housekeeping, shopping, laundry, transportation, etc), companion or respite services. Other restrictions apply. ***Please check with your case manager or consultant before requesting your spouse to be a paid caregiver.***
6. Though some individuals may choose to hire friends or family to be paid by CFC, please note that CFC is not an employment program.
7. Individuals who wish to be a certified employer for consumer or surrogate directed services must be certified by the case manager or consultant. Employer certification is reviewed annually and is subject to change. ***For more information, ask your case manager, consultant or payroll agent for an Employer Handbook.***

What is Medicaid Fraud?

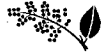
Medicaid fraud is when an **EMPLOYER** or **EMPLOYEE** is untruthful regarding Choices for Care (CFC) services provided, in order to obtain improper payment. It is also considered Medicaid fraud when an individual knowingly gives false, incorrect, incomplete, or misleading information in order to be eligible for Long-Term Care Medicaid.

The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit Medicaid fraud. Medicaid fraud is a felony and conviction can lead to substantial penalties (including but not limited to, imprisonment up to ten years, or a fine up to \$1,000 or an amount equal to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be excluded for a minimum of five years from any employment with a program or facility receiving Medicaid funding.

Some examples of Medicaid fraud include:

- Submitting timesheets for services not actually provided
- Submitting timesheets for services provided by a different person
- Misrepresenting your needs.
- Not telling the Department for Children and Families (DCF) about assets you own that are counted in financial eligibility. (e.g. property you own in a another state or a bank account with your name on it)

NOTE: Suspected cases of fraud will be referred to the Attorney General's Medicaid Fraud Control Unit and may be referred to the local police authorities for further investigation and possible prosecution. If you suspect Medicaid Fraud, contact the Attorney General's office at (802) 241-4440.

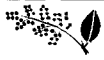


CHAPTER V: Your Rights

What are your rights on this program?

As a participant of the Choices for Care program, you have the following rights:

1. You have a right to be treated with dignity and respect.
2. You have a right to information.
3. You have a right to privacy.
4. You have a right to participate in the development and implementation of your services.
5. You or your legal guardian, have a right to make your own decisions.
6. You have a right to appeal adverse decisions made by the state.
7. You have a right to make a complaint when you are not happy with the services you are receiving.
8. You have a right to receive competent, considerate, respectful care from Choices for Care providers.
9. You have a right to withdraw from the program at any time.



CHAPTER VI: Your Responsibilities

What are your responsibilities on this program?

As a program participant, you have a very important role in the Choices for Care program. Here are some of your key responsibilities as a participant of this program:

1. Participate fully in your assessment and care plan process.
2. Provide complete and accurate information.
3. Keep appointments with your providers of care. Let them know ahead of time when an appointment can not be kept.
4. Authorize the LTCCC, your case manager and providers to obtain necessary records and information regarding your care and program eligibility.
5. Participate in your care as much and as you can. Ask your provider of services if there are ways you can safely become more independent and involved in your care. Ask about assistive devices, durable medical equipment or therapy services.
6. Complete all DCF forms in a timely manner to keep your LTC Medicaid eligibility.
7. Notify DCF within ten (10) days of the change when you have a change in your income, resources, medical expenses, insurance premiums or coverage.
8. Notify your providers and DCF immediately if you have a change of address.
9. Notify your case manager, DCF, and provider of service if you will be out of the state for more than 30 days.
10. Report changes in your care needs and health status to your case manager or provider of services. Let them know when you need more or less help.
11. Help your providers be as efficient as they can.
12. If you are unhappy with your services, ask your case manager or the provider of your service who you can talk to so you can fix the problem.
13. If you receive care at home, develop an emergency backup plan for care and services with your case manager.
14. Pay your patient share on time each month if you have one.
15. Learn as much as you can about the program, what it can offer and what are the limitations.
16. Understand that Choices for Care is funded through Medicaid by the federal and VT state government. Funding is limited, so services provided to you must be as effective and efficient as possible.
17. Provide feedback about the program and your services when you are asked. The only way to improve the program is for providers and the Department to better understand the problems.

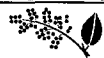


CHAPTER VII: Provider Responsibilities

What are the provider responsibilities on this program?

All Choices for Care providers of service must follow program standards. Their key responsibilities to you are:

1. Comply with all applicable provider qualifications, standards and regulations.
2. Ensure that all staff with direct participant contact has passed a background check, according to the DAIL Background Check Policy (April 1, 2006).
3. Provide services according to service principles, definitions, standards, approved activities, and limitations.
4. Provide services in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks.
5. Implement structured internal complaint and appeals procedures.
6. Fully inform individuals of their rights and responsibilities in working with the agency, including both internal and formal complaint and appeal procedures.
7. Encourage and assist the participant to direct as much of her/his own care as possible.
8. Implement policies and procedures that will be used to supervise and/or monitor services.
9. Follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting of abuse, neglect, and exploitation.
10. Demonstrate to the DAIL that they have sufficient expertise and capacity to meet the needs of the target population, including effective working relationships with other local or regional providers and agencies.
11. Ensure services are provided as defined in the approved CFC Service Plan (when applicable).
12. Ensure that staff has the skills and/or training required to meet the needs of the individual.
13. Maintain accurate and complete documentation of services provided to the individual.
14. Report any concerns about services or the individual's status and condition to the individual's case manager, if the individual is in the home-based or ERC setting.
15. Ensure that the volume of services and rate charged to the State are based on services actually provided to the participant, within the limits specified in the approved Service Plan.
16. Avoid conflicts of interest between the interests of the individual and the interests of the provider and its staff.
17. Assist the State in ensuring that services are provided in compliance with the standards, policies and procedures established by the State. This includes participating in structured evaluation activities developed by the State.
18. Abide by principles of confidentiality and all applicable confidentiality policies and laws.
19. Comply with all applicable laws and regulations regarding employment, including the provision of workers compensation insurance and unemployment insurance to employees.



CHAPTER VIII: Abuse, Neglect, & Exploitation

What is Abuse, Neglect, and Exploitation?

ABUSE - Abuse can be any action (including unnecessary restraint or confinement) that threatens a vulnerable adults' physical or emotional health or welfare. Any sexual activity between a vulnerable adult and a volunteer or paid caregiver employed by a facility of program is also **abuse**. Providing or threatening to provide a drug or other potentially harmful substance to a vulnerable adult for other than lawful and legitimate medical or therapeutic treatment is **abuse**.

NEGLECT- Neglect is the purposeful or reckless failure by a caregiver to provide adequate care (the goods, services and plans needed to maintain reasonable health and safety) to a vulnerable adult. Neglect is also the failure of a caregiver to report significant changes in the health of a vulnerable adult or the failure to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others.

EXPLOITATION - Exploitation is the willful unauthorized transfer or use of a vulnerable adult's property and includes interest in or control of assets or gain through undue influence or fraud. It is **exploitation** to force or compel a vulnerable adult to perform services for the profit or advantage of another. **Exploitation** also covers any non-consensual sexual activity with a vulnerable adult.

Who is required to report Abuse, Neglect, and Exploitation?

The State of Vermont requires, by law (Title 33, VT Statue), that all health professionals report cases of suspected abuse, neglect, and exploitation of a vulnerable adult to Adult Protective Services. Examples of people who must report are:

- Case Managers,
- Personal Care Attendants,
- Respite Care Workers,
- Companion Workers,
- Home Health Agency Employees,
- Adult Day Employees,
- Residential Care Home & Assisted Living Residence Employees,
- Nursing Facility Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- Payroll Agent (ARIS)

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation. In most cases, the identity of the individual making the report shall remain confidential.

Reports are made by contacting the Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, Adult Protective Services (APS) at 1-800-564-1612 or online at <http://www.dail.state.vt.us/lp/aps.htm>.

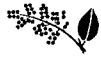


Table A: Who to Contact When?

Type of Question or Issue	Contact
Abuse, Neglect, Exploitation.	Adult Protective Services 1-800-564-1612
Appeal a decision made by DAIL.	DAIL 241-2401
Appeal a decision made by DCF.	Local DCF office (see table D. 4)
Clinical eligibility.	Local LTCCC (see table D. 1)
Complaints about the care and services provided by a facility or agency that provides health care.	Division of Licensing and Protection 1-800-564-1612
Financial Eligibility.	Local DCF/ESD (see table D. 4)
General Choices for Care program questions.	Your case manager, provider of care, the local LTCCC or DAIL Waterbury Central Office (see table D.)
Health care and health insurance coverage problems.	VT Office of Health Care Ombudsman 1-800-917-7787
Help to resolve problems regarding Choices for Care denials, quality of care, finding care or services as well as education about long-term care services.	VT Long-Term Care Ombudsman 1-800-889-2047
Help finding caregivers.	Rewarding Work Caregiver Registry: http://www.rewardingwork.org/ or HomeShare VT 802 863-5625 or speak with your case manager.
Home Health Services.	Local Home Health Agency (see table D. 3)
Legal assistance.	VT Legal Aid 1-800-889-2047
Lists of licensed Residential Care Homes, Assisted Living Residences, Nursing Facilities, Home Health Agencies, Hospitals, etc.	Division of Licensing and Protection 1-800-564-1612
Payroll questions for consumer or surrogate directed services.	ARIS Solutions 1-800-798-1658
Peer counseling and assistance for adults with disabilities.	VT Center for Independent Living 1-800-639-1522
Services for Adults 60 years and older.	Local Area Agency on Aging (see table D. 2)



Table B: State Websites

Agency/Department	Website
Department for Children and Families (DCF):	http://www.dcf.vermont.gov/
Department of Disabilities, Aging and Independent Living (DAIL):	http://dail.vermont.gov/
Division of Disabilities and Aging Services (DDAS):	http://www.ddas.vermont.gov/
Division of Licensing and Protection (DLP)	http://www.dail.state.vt.us/lp/
Economic Services Division (ESD):	http://www.dcf.vermont.gov/esd
Office of VT Health Access (OVHA):	http://ovha.vermont.gov/
Other Resources:	http://www.ddas.vermont.gov/ddas-resources

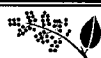


Table C: Publications

Publication	Located
Choices for Care Forms	DAIL: (802) 241-1228 http://www.ddas.vermont.gov/
Choices for Care Policies and Guidelines	DAIL: (802) 241-1228 http://www.ddas.vermont.gov/
Choices for Care Program Manual	DAIL: (802) 241-1228 http://www.ddas.vermont.gov/
Choices for Care Regulations	DAIL: (802) 241-1228 http://dail.vermont.gov/dail-statutes
Home Health Agency Regulations	DLP: (802) 241-2345 http://dail.vermont.gov/dail-statutes
Residential Care Home Regulations	DLP: (802) 241-2345 http://dail.vermont.gov/dail-statutes
Nursing Facility Regulations	DLP: (802) 241-2345 http://dail.vermont.gov/dail-statutes

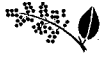


Table D: Local Contacts

1. Long-Term Care Clinical Coordinators (DAIL/DDAS)

District Office	Phone	Fax
Barre	(802) 476-1646	(802) 476-1654
Bennington	(802) 447-2850	(802) 447-2789
Brattleboro	(802) 251-2118	(802) 254-6394
Burlington	(802) 879-5904	(802) 879-5620
Hartford	(802) 296-5592	(802) 295-4148
Middlebury	(802) 388-5730	(802) 388-4637
Morrisville	(802) 888-0510	(802) 888-0536
Newport	(802) 334-3910	(802) 334-3386
Rutland	(802) 786-5971	(802) 786-5882
Springfield	(802) 885-8875	(802) 885-8879
St. Albans	(802) 524-7913	(802) 527-4078
St. Johnsbury	(802) 748-8361	(802) 751-2644
Waterbury Central Office	(802) 241-1228	(802) 241-4224

2. Local Area Agencies on Aging (Senior Helpline: 1-800-642-5119)

Champlain Valley Agency on Aging	(802) 865-0360
Northeastern VT Area Agency on Aging	(802) 748-5182
Central VT Council on Aging	(802) 479-0531
Southwestern VT Council on Aging: Bennington	(802) 442-5436
Rutland	(802) 786-5991
Southeastern VT Council on Aging	(802) 885-2655

3. Local Home Health Agencies

Addison County Home Health & Hospice	(802) 388-7259
Bennington Area Home Health	(802) 442-5502
Caledonia Home Health	(802) 748-8116
Central VT Home Health	(802) 223-1878
Chittenden / Grand Isle Visiting Nurse Association	(802) 658-1900 (TDD) or (800) 833-6111
Franklin County Home Health Agency	(802) 527-7531
Lamoille Home Health	(802) 888-4651
Manchester Health Services	(802) 362-2126
Orleans / Essex Visiting Nurse Association	(802) 334-5213
Professional Nurses Services	(800) 446-8773
Rutland Area Visiting Nurse Association	(802) 775-0568
Visiting Nurse Alliance of VT & NH	(800) 858-1696

4. DCF/ESD District Offices

Barre	(802) 479-1041 or 800 499-0113
Bennington	(802) 442-8541 or 800 775-0527
Brattleboro	(802) 257-2820 or 800 775-0515
Burlington	(802) 863-7365 or 800 775-0506
Hartford	(802) 295-8855 or 800 775-0507
Middlebury	(802) 388-3146 or 800 244-2035
Newport	(802) 334-6504 or 800 775-0526
Rutland	(802) 786-5800 or 800 775-0516
Springfield	(802) 886-8856 or 800 589-5775
St. Albans	(802) 524-7900 or 800 660-4513
St. Johnsbury	(802) 748-5193 or 800 775-0514
Waterbury Central Office	(802) 241-2800

Vermont 2-1-1: Vermont 2-1-1 is a simple number to dial for information about health and human service organizations in your community. By dialing 2-1-1, information is much easier to find. Callers will speak with a real person every time. Call Specialists will problem solve and refer callers from throughout Vermont to government programs, community-based organizations, support groups, and other local resources.

More information can be found online at: <http://www.vermont211.org/>.

APPENDIX D
DRAFT INFORMED CONSENT FORM

APPENDIX D

Choices for Care

Consent to Participate in Vermont Money Follows the Person Program

I, _____, freely choose to participate in the Vermont Money Follows the Person (MFP) program. I understand that this program allows me to receive a limited amount of flexible funds for expenses related to my transition from the nursing facility where I currently live to a new home in the community.

I have received information about the MFP program and am aware of all aspects of the transition process. I have also received information about the services and supports that will be provided to me both during the MFP demonstration and thereafter, which are all part of the Choices For Care Program.

I understand that participation in MFP is voluntary and that I can withdraw from participation in the MFP project at any time. I understand that I will participate in developing a plan of care that outlines my services, a backup plan and my emergency contact list.

I understand that agreeing to participate in the MFP program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my MFP program eligibility. I understand that there are no additional risks anticipated based on my participation in the MFP program beyond the risks related to receiving services in a community setting, for which I have already provided my consent. I have also been provided with a copy of the Choices For Care Participant Handbook that outlines my rights and responsibilities.

In order to participate in the MFP program, I have been informed that I must meet all of the eligibility requirements specific to the MFP program, which include residing in an inpatient facility for at least ninety (90) consecutive days; receiving Medicaid benefits for inpatient services; and that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 4 other unrelated individuals reside.

As an MFP participant, I will be asked to complete three short surveys about my quality of life. I will still be eligible to receive flexible funds for transition even if I do not complete the surveys. I understand that any information collected about me will be kept confidential and only be used for evaluating the project.

If I am re-institutionalized for more than thirty (30) consecutive days, I will be reevaluated for continued MFP eligibility and have an updated plan of care developed. If after three incidences/occurrences of re-institutionalization of thirty (30) consecutive days or longer I may no longer be considered for reentry into the MFP Project.

My signature below indicates that I agree to participate in the MFP program if I am determined eligible and that any questions that I may have about the program have been answered.

APPENDIX D

<u>MFP Participant Acknowledgement</u>	
Participant Name	
Participant Signature	
Date Signed:	
<u>Guardian/Legal Representative Acknowledgement (if applicable)</u>	
Guardian/Legal Representative Name	
Guardian/Legal Representative Signature	
Date Signed:	
<u>Transition Coordinator Acknowledgement</u>	
Transition Coordinator Name	
Transition Coordinator Signature	
Date Signed:	

APPENDIX E
LETTERS OF ENDORSEMENT

APPENDIX E

December 29, 2010

Susan Besio, Ph.D., Commissioner

Department of Vermont Health Access (DVHA)

312 Hurricane Lane, Suite 201

Williston, Vermont 05495

Dear Commissioner Besio:

I am a private citizen and consumer enrolled in the Vermont Choices for Care waiver—a waiver that enables me to live in the community. Because I live in the community, I am able to have a tortoise and to attend school and to work. I can also personalize my apartment with decorations, and set in up in the most accessible way possible. These freedoms that I experience should be available to all. To this end, I am writing to endorse the state's application for funding under the Money Follows the Person Grant Program.

All Vermonters receiving long term care should have the option of remaining in, or returning to the community, if it safe to do so. The Money Follows the Person program will make this choice available to nursing facility residents who today lack housing alternatives and face other challenges that keep them in a nursing facility. As my example shows, community living greatly enriches my life. Vermont has long been a leader in deinstitutionalization for individuals with disabilities. Granting the state this Money Follows the Person application allows the state to uphold its tradition of inclusion and to continue serving as a model for other states. I know that funders prefer results that are easily quantifiable, with high numbers. The fact of the matter is, though, I cannot quantify my enjoyment at living in an environment among my peers. Although the fiscal costs of Money Follows the Person may be high, the positive results for former facility residents are incalculable. If this country truly is going to practice what it preaches in terms of liberty and justice for all, then facility residents must have the liberty to live in the community if they choose to do so. Many studies have proved it is cheaper to keep someone in the community than to house them in a facility.

Thank you for creating the Money Follows the Person program. I hope you will approve Vermont's request and provide the funding necessary to help residents of nursing facilities in our state who wish to return to their communities.

Sincerely,
Jill M. Allen

412 Farrell Street, Suite 300
South Burlington, VT 05403
(802) 863-5625



E-mail: home@sover.net
Website: HomeShareVermont.org
Fax: (802) 651-0881

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- Chris Walker

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- Amy Jelen
Homesharing Coordinator
- MaryLou Thorpe
Caregiving Coordinator
- Dorothy Howe
Office Assistant
- Holly Reed
Office Manager
- Alexis Seubert
AmeriCorps Member

December 27, 2010

Susan Besio, Commissioner
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

RE: Letter of Support

Dear Commissioner Besio:

I am writing on behalf of HomeShare Vermont in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

HomeShare Vermont works with elders and persons with disabilities to help them stay in their homes and we match them with people looking for an affordable place to live who can offer some service in exchange for reduced rent. We have over twenty-five years of experience in recruiting, screening and matching people interested in homesharing. We work closely with the Vermont Department of Disabilities, Aging and Independent Living.

Through the Choices for Care Waiver, Vermont has been a leader in providing alternatives to nursing facility placement for people who need long term care. Vermont has an excellent infrastructure of programs and services designed to help people stay at home or return home. The Money Follows the Person Demonstration offers another option for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this grant application.

Sincerely,

Kirby Dunn
Executive Director





APPENDIX E

State of Vermont
Department of Mental Health
Office of the Commissioner
103 South Main Street
Wasson Hall
Waterbury, VT 05671-2510
www.mentalhealth.vermont.gov

Agency of Human Services

[phone] 802-241-4008
[fax] 802-241-4009
[tty] 800-253-0191

December 27, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

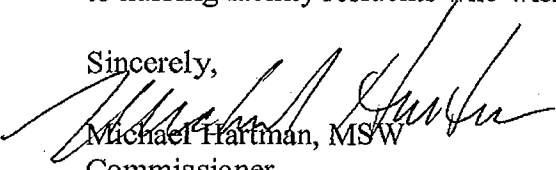
Dear Commissioner Besio:

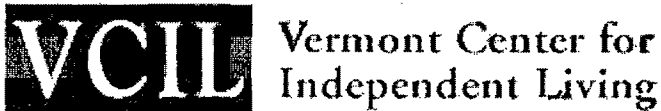
I am writing on behalf of the Department of Mental Health in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

The receipt of these funds would allow for an expansion of the work that our state has done to move persons with long term care needs out of institutional care. DMH would see this grant as helpful to nurture the mental health provider system in supporting these persons who do have physical care need, but also have mental wellness support needs. As the primary contractor for community based mental health services DMH would work to create access points for persons who might receive services via this application. This would also serve to further increase the DMH and Department of Disabilities, Aging, and Independent Living (DAIL) collaborations to improve mental health services for elders and others with long term needs.

Vermont has been a leader, through the Choices for Care waiver, in providing alternatives to nursing facility placement for new entrants into the long term care program. DMH believes the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this effort.

Sincerely,


Michael Hartman, MSW
Commissioner



Citizens with disabilities working together for dignity, independence, and civil rights

December 30, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

On behalf of the Vermont Center for Independent Living I am writing in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

As you know the Vermont Center for Independent Living is a statewide nonprofit organization of people with disabilities working together for dignity, independence and civil rights. For over thirty-one years, VCIL has been working to promote the full inclusion of Vermonters with disabilities into community life and have fought against people living in institutions when there is a preference for living in the community.

Vermont has been a leader, through the Choices for Care waiver, in providing alternatives to nursing facility placement for new entrants into the long term care program. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this program, and look forward to working with the state on efforts related to the demonstration.

Yours truly,

A handwritten signature in black ink that reads "Sarah Launderville". The signature is written in a cursive, flowing style.

Sarah Wendell Launderville
Executive Director

11 East State Street, Montpelier, VT 05602
802 229-0501, 800 639-1522 (voice & TTY), fax: 802 229-0503
email: vcil@vcil.org web site: www.vcil.org



With offices in Bennington, Chittenden, Orleans, Rutland, and Windham Counties

Community of Vermont Elders

December 28, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

I am writing on behalf of Community of Vermont Elders (COVE) in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

COVE's mission is to promote and protect a higher quality of life for Vermont seniors through education and advocacy. Though COVE is not a direct service provider we strongly support programs that allow optimal choice for consumers.

Through the Choices for Care waiver Vermont has been a leader in providing alternatives to nursing facility placement for new entrants into the long term care program. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this effort.

Sincerely,



Thomas C. Davis
COVE President

APPENDIX E

December 27, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

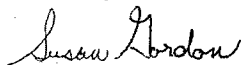
Dear Commissioner Besio:

I am writing on behalf of the DAIL Advisory Board in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Program.

The DAIL Advisory Board was created for the purpose of advising the commissioner with respect to programs and issues affecting older persons and persons with disabilities. We meet monthly throughout the year to learn about DAIL programs, pose thoughtful questions and provide advice and additional input to staff and the leadership. We have closely followed Vermont's approach to increasing the number and quality of home and community based services through the Choices for Care program.

We know that Vermont has been a national leader, through the Choices for Care waiver, in providing alternatives to nursing home placement for new entrants into the long term care system. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to existing residents of nursing facilities who have improved conditions and/or opportunities for support and who wish to return to the community. We strongly endorse this effort.

Sincerely,



Susan Gordon
DAIL Advisory Board Chairperson

APPENDIX E

Vermont Association of Area Agencies on Aging

Helping Vermonters Age with Independence and Dignity

December 20, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

Thank you for the opportunity to offer our collective support for the Department's application for funding under the Money Follows the Person Rebalancing Grant Demonstration Program. As you know, the Area Agencies on Aging have promoted consumer choice and independent living for seniors and adults with disabilities for over three decades. We welcome the opportunity to partner with the state and other community providers to further these goals.

We are deeply committed to providing personal choice to those who are frail and disabled. The staff of our member organizations provides support in a variety of forms to over 10,000 consumers and family caregiver each year, all with the goal of helping these individuals maximize their personal independence in a manner consistent with their values and preferences. We believe that Vermont's participation in the Money Follows the Person Demonstration can further advance our work in this regard, and enthusiastically offer our support for this initiative.

As you know, Vermont has been a leader, through the Choices for Care waiver, in providing alternatives to nursing facility placement for new entrants into the long term care program. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this effort, and stand ready to assist with both material and in-kind support. Please let me know if we can be of additional assistance.

Sincerely,



Ken Gordon, President
Vermont Association of Area Agencies on Aging

Appendix E-7



Champlain Valley
Agency on Aging, Inc.
802-865-0360
www.cvaa.org



Northeastern Vermont
Area Agency on Aging, Inc.
802-748-5152
www.nevaag.org



Central Vermont
Council on Aging, Inc.
802-479-0531
www.cvcoa.org



Southwestern Vermont
Council on Aging, Inc.
802-786-5991
www.svcoa.org



Council on Aging
for Southeastern Vermont, Inc.
Appendix E-885-2655
www.coasevt.org

APPENDIX F
CHOICES FOR CARE EMERGENCY CONTACTS AND BACK-UP PLAN

Choices for Care-Department of Disabilities, Aging and Independent Living

Emergency Contacts & Back-up Plan

This plan shall be reviewed and updated by the case manager as needed. A copy must be maintained in the individual's home in a conspicuous place.

Date created: _____

I. Emergency Contacts

In the event of a medical emergency or fire, call 911.

Emergency family/friend contact: _____

Relationship to individual: _____

Phone numbers: _____/home _____/work

Primary Doctor: _____

Normal hours of operation: _____ phone number: _____

After-hours on-call phone number: _____

Home Health Agency: _____

Normal hours of operation: _____ phone number: _____

After-hours on-call phone number: _____

Case Management Agency: _____

Normal hours of operation: _____ phone number: _____

After-hours on-call phone number: _____

NOTE: Individuals enrolled with a **Personal Emergency Response System (PERS)** provider may push the PERS button in any emergency. For questions regarding PERS services, contact your case manager.

II. Back-up Personal Care

In the event that the personal care attendant is unavailable, indicate at least one confirmed back-up person to contact that can fill-in to provide or arrange for care:

1. Name: _____

Relationship to individual: _____

Phone numbers: _____/home _____/work

2. Name: _____

Relationship to individual: _____

Phone numbers: _____/home _____/work

If none, indicate reason:

APPENDIX G
SUB APPENDIX 1 – SELF-DIRECTION SUBMITTAL FORM

APPENDIX G

Sub-Appendix I: Self-Direction

Components of Self-Direction from the 1915(c), 3.5 Waiver Application

Participant direction of waiver services means that the participant has the authority to exercise decision making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered service plan. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a service is provider-managed, a provider selected by the participant carries out these responsibilities.

Incorporating participant direction involves several interrelated dimensions. The following is an overview of the main dimensions of participant direction:

Participant Choice

Self-direction may permit participants to direct some or all of their services or opt instead to receive provider-managed services exclusively. Decision making authority, references to the participant mean: (a) the participant acting independently on her/his own; (b) the parent(s) of a minor child who is a waiver participant acting on behalf of the child; (c) a legal representative when the representative has the authority to make pertinent decisions on behalf of the participant; and, (d) when permitted by the state, a non-legal representative who has been freely chosen by the participant to make decisions on the participant's behalf.

Participant Direction Opportunities

There are two basic participant direction opportunities. These opportunities may be and often are used in combination and are not mutually exclusive. The opportunities are:

- **Participant Employer Authority.** Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law employer or the co-employer of these workers. When the Employer Authority is utilized, the participant rather than a provider agency carries out employer responsibilities for workers.
- **Participant Budget Authority.** Under the Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. Depending on the dimensions of the budget authority it permits the participant to make decisions about the acquisition of goods and services that are authorized in the service plan and to manage the dollars included in a participant-directed budget.

Supports for Participant Direction

Two types of supports may be made *available* to facilitate participant direction. These supports may be furnished as a service under a Medicaid payment authority (principally as a Medicaid administrative activity).

- **Information and Assistance in Support of Participant Direction:** These supports are made available to participants to help them manage their waiver services. For example, assistance might be provided to help the participant locate workers who furnish direct supports or in crafting the service plan. The type and extent of the supports that must be available to participants depends on the nature of the participant direction opportunities provided.
- **Financial Management Services:** These services are furnished for two purposes: (a) to address Federal, state and local employment tax, labor and workers' compensation insurance rules and other requirements that apply when the participant functions as the employer of workers and (b) to make financial transactions on behalf of the participant when the participant has budget authority. There are two types of FMS services that may be employed to support participants who exercise the Employer Authority: (1) Fiscal/Employer Agent (Government or Vendor) where the entity is the agent to the common law employer who is either the participant or his or her representative or (2) Agency with Choice, where the participant and the agency function as co-employers of the participant's worker(s). While their main purpose is to facilitate participant direction of services, these supports also provide important protections and safeguards for participants who direct their own waiver services.

CMS Funding Sources

Self-Direction can be funded by a variety of mechanisms by CMS, including funding authorities such as section 1915(c) home and community-based services waiver programs and section 1915(b) managed care, waiver programs. The Deficit Reduction Act of 2005 added new options for self-directed services States that wish to continue self-direction beyond the grant period for individuals will need to consider which authority to use. These options are summarized in the table below. (Note: section 1915(c) waiver authority policy on self-direction was developed in conjunction with the 1915(c) waiver application and is comprehensively documented in the Instructions, Technical Guide and Review Criteria for the application found at the following website: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers

Reading the provisions in the 1915(c) waiver template are a good starting point for all self-direction initiatives. Various restrictions are present under this and other authorities and CMS should be consulted if you have questions about the authority that is best suited to your circumstances. The following table summarizes significant issues under the various authorities.

	Component		Funding Authority		
	1915(c)	1915(b)	Benchmarks (DRA 6044)	Section 1915(i) (DRA 6086)	Section 1915(j) (DRA 6087)
Services	See Appendix C of the waiver instructions for service options	Includes ability to use savings from managed care programs to fund alternative services	Includes ability to create enhanced service packages	Includes HCBS allowed under 1915(c)	Can self-direct either State plan PCS or HCBS under 1915(c)
State -wideness	May waive	May waive	May waive	Cannot-	States may disregard
Comparability	States may waive	States may waive	States may waive	Cannot	States may disregard
Populations	Populations who meet a Medicaid institutional level of care	Includes all populations	Includes all populations	Includes all populations	Includes all populations
Authority to Manage Cash	Cannot manage cash	Cannot manage cash	May not manage cash	May not manage cash	Allowed, at State's option
Limit #s of people	May limit numbers	May limit numbers	May limit numbers	May not limit numbers	May limit numbers
Institutional Eligibility Rules	May waive	May waive	May waive	May waive	Does not change person's eligibility for either State plan PCS or HCBS waiver services
[1902(a)(10)(c)(i)(III)] Provider Agreements [1902(a)(27)]	May not waive	May not waive	May not waive	May not waive	May not waive

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager. <i>Specify qualifications:</i> All case managers must complete the required state case management training and also receive appropriate supervision. All case managers must be certified. Certification remains in effect unless revoked by DAIL.
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>): Transition Coordinators: Hired by DAIL: Qualifications – Minimum of a Bachelor’s Degree in either Health or Human Services.

b. **Service Plan Development Safeguards.** *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i> Both Agencies on Aging and Home Health Agencies may provide case management services. Home Health Agencies also may provide personal care, respite and companion services. Consumers have a choice of case management agencies.

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Transition coordinators and/or case managers assist the participant (and/or family or legal representative) to direct and be actively engaged in developing and implementing a service/care plan that addresses the individual's needs, preferences, risk factors, and backup plan. At the discretion of the participant, transition coordinators and/or case managers assist the participant to identify family and/or representative/surrogate supports, caregivers, and others to assist and participate in the service/care planning process and to attend the service/care planning meeting. The participant is also encouraged to be actively involved.

- d. **Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

There are currently three options for self-direction under Vermont's 1115 LTC waiver, Choices For Care, that will be available to MFP participants: self-direction, surrogate-direction and Flexible Choices Program. All three of the options begin with an assessment and the development of the service/care plan to assess an individual's interest in self-directing. The transition coordinator and/or case manager will contact the individual and make arrangements for the completion of the transition assessment, also known as the "Independent Living Assessment (ILA)". This assessment is a comprehensive assessment that involves a complete health and functional needs assessment as well as a risk assessment. The ILA also measures cognitive status. The ILA also assesses mental health status and will provide the transition coordinator and/or case manager with the information needed to develop a care plan to address all of these needs.

To self-direct, the individual must have the cognitive ability to communicate effectively. A registered nurse will complete the ILA and the individual is encouraged to include informal supports in the process. These include family, representatives, surrogates, caregivers, etc. The transition coordinator and/or case manager will assess the individual's circumstances, resources, program eligibility, and formal and informal support systems, as well as the individual's preferences and goals for self-directing services. The results of the assessment will serve as the basis for the development of the individual's plan of care.

The transition coordinator and/or case manager will conduct a review of service options and

discuss any limitations with the individual or their representative/surrogate. The transition coordinator and/or case manager will, in conjunction with the individual and/or their representative/surrogate develop a comprehensive service/care plan that addresses his/her needs. The participant will review the service/care plan and sign-off on the service plan. The completed assessment and signed service plan will be sent to DAIL for staff level review. A copy of the service plan once approved will be given to the participant. Once approved, the individual becomes the employer in consumer/surrogate self-direction. The transition coordinators and/or case managers are trained in the nuances of consumer and surrogate-directed services and are competent in assisting participants in operationalizing this option.

A consumer and surrogate-directed service handbook is given to the individual that offers detailed guidance on the roles and responsibilities of an employer. With the Flexible Choice option the assessment process is the same, only with the consultant in the role of the case manager. Working with the consultant, the individual then develops a budget which details expenditures of the allowance and guides the individual's acquisition of services to meet their needs.

MFP demonstration services will enhance the range of services available to the participant but will not duplicate or supplant. Qualified HCBS including SD/CD and Flexible Option currently covered under the existing CFC program will be offered to MFP participants both during and after the 365-day MFP waiver period. The case manager will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They will also ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained.

The participant will be reassessed annually and/or if there is any change in health/condition or needs status. The case manager or consultant will be in contact with the participant at least quarterly while in self-direction. MFP quality management specialists will assure that quality controls are maintained. DAIL tracks the contents of all care/service plans and compares the actual utilization of services by the participant to those services included in the care plan. Other standard monitoring practices include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, and resolution and data analysis.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Transition coordinators will complete transition assessments on all MFP participants prior to them leaving a nursing facility. The transition assessment will identify potential risks in transitioning to the community, including situational, environmental, behavioral, medical and financial. The transition coordinator, in collaboration with the participant and the participant's assigned case manager, will develop a care plan. The care plan will identify and document strategies to address the risks identified in the transition assessment as well as an emergency backup plan. Upon completion of the care plan, a copy will be provided to the participant. Care plans will be implemented and monitored by the participant's assigned case manager. The assessment and plan of care are updated at least annually and more often if warranted by changes in the participant's situation or condition.

At the time the care plan is developed, the case manager will assist the individual in developing an emergency backup plan. This plan will indicate at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. This could consist of both formal and informal providers, such as family, friends and neighbors who have agreed to support the participant on an emergency basis. It will also include a list of emergency contacts.

DAIL clinical staff (LTCCCs) will conduct a thorough utilization review prior to authorizing any modifications to the annual service plan. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They will also ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained. They will also monitor, directly or indirectly, the delivery of services under the care plans and track the proportion of services included in the plan that are actually delivered to the enrollee.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

When an individual chooses self-direction, either CD/SD or Flexible Option, they are given a list of qualified services providers and qualified providers. The list will be provided by the transition coordinator and/or case manager after the completion of the initial assessment, care plan and service plan. This will enable the individual to identify what qualified providers are available for the services they can self-direct to begin their selection process.

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The completed assessment and signed service plan will be sent to DAIL for staff level review

and approval. DAIL clinical staff (LTCCCs) conduct a thorough utilization review of each service/care plan. A copy of the service/care plan, once approved, is given to the individual.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Department of Disability, Aging and Independent Living (DAIL
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

II. Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The MFP demonstration program will be targeting the Elderly and Physically Disabled population. Transition Coordinators and/or case managers will be responsible for the monitoring and implementation of the service plan and participant health and welfare. The monitoring and follow-up methods will be an annual reassessment by the case manager, at the request of the individual, and/or if there is any change in health/condition or needs status. The case manager will have monthly contact or more frequent if needed with the individual. The annual reassessment will be face-to-face by the case manager. Other standard monitoring practices performed by the case manager and/or QM specialists include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, resolution and data analysis. Complaints of abuse, neglect and exploitation are investigated by DAIL and then referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Fraud Unit.

- b. **Monitoring Safeguards.** *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>
	Both Agencies on Aging and Home Health Agencies may provide case management services. Home Health Agencies may also provide personal care, respite and companion services. Consumers have choice of case management agencies and may change case management agencies at any time.

III. Overview of Self-Direction

- a. **Description of Self-Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

A: Opportunities afforded to participants: Individuals who are interested in self-directing their supports are made aware that as part of the MFP demonstration under the 1115 long term care waiver there are three choices to self-direct. Both the Consumer-directed (CD) care and the Surrogate-directed (SD) care options allow consumers to hire and manage workers to provide the consumer with personal care, respite or companion services. Under the CD option, the consumer is the employer and under the SD option, a surrogate appointed by the consumer is the employer. The third option, Flexible Choices, provides the consumer or an appointed surrogate with a limited monetary allocation, known as an "allowance" that may be used to hire workers or purchase other goods or services necessary for the consumer's ongoing support needs. **B:** All three of the options begin with the development of the service/care plan. The transition coordinator and/or case manager will contact the individual participant and make arrangements for the completion of the transition assessment called the Independent Living Assessment (ILA). This is done initially, annually and as needed. Transition Coordinators and/or case managers inform participants of the option to self-direct at these times. At any time the participant can chose to self-direct or terminate the self-direction option by notifying the transition coordinator and/or case manager. The transition coordinator and/or case manager will work with the participant to make sure that there is a seamless transition to another option offered through the 1115 long term care waiver, CFC.

C. In Flexible Choices, a contracted consultant will be assigned to help the participant manage their budget and perform tasks that include by not limited to: assuring that the participant has in place an emergency back-up plan; monitoring the services included in an individual's budget; assessing the adequacy of care being provided; certifying the ability of a consumer or surrogate employer to manage services; reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services; and reporting suspected cases of Medicaid Fraud to the State Medicaid Fraud Unit.

Under Flexible Choices, all expenses incurred by participants are billed through the Fiscal Intermediary Services Organization (ISO). The ISO assist the participant and/or representative to manage and distribute funds contained in their budget to include but not limited to: payroll including federal, state and local tax withholdings/payments; unemployment compensation fees, making payments for goods and services; fiscal accounting and expenditure reports. The ISO is required to be utilized by the participant and/or representative that chose to use Flexible Choices.

For those who are enrolled in the consumer or surrogate directed options, an assigned case manager is responsible for:

- Answering questions about the CFC program;
- Assisting individuals in gaining access to needed services;

- Overseeing the assessment and reassessment of the individual;
 - Developing a service plan for the individual;
 - Monitoring the services included in an individual's service plan;
 - Assessing the adequacy of care being provided;
 - Certifying the ability of a consumer or surrogate employer to manage services;
 - Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services; and
 - Reporting suspected cases of Medicaid Fraud to the State (see Chapter VIII).
- D. No other relevant information

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the demonstration. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in Appendix E-2, Item a , the participant (or the participant’s representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in Appendix E-2, Item b , the participant (or the participant’s representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The demonstration provides for both participant direction opportunities as specified in the 1115 long term waiver Appendix E-2 . Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
<input checked="" type="checkbox"/>	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual’s family has domain and control.

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (select one):

X	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time the participant expresses an interest in self-direction, the transition coordinator and/or case manager will provide him/her with the CFC Employer Handbook, Flexible Choices brochures and other informational materials on SD/CD and Flexible Choices. The participant will also be given the **"Help at Home: A Guide to Finding and Keeping Your Caregiver"** (published by Homeshare Vermont, Burlington, VT), for helpful information and tips on hiring, training and keeping caregivers/workers. **EMPLOYERS** may obtain a guide by contacting the Choices for Care case manager or Homeshare Vermont or <http://www.homesharevermont.org/>. This information can be given at the initial assessment, at any reassessment or when the participant request or expresses an interest in self-direction.

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of demonstration services by a representative (select one):

O	The State does not provide for the direction of demonstration services by a representative.	
X	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: (check each that applies):	
	X	Demonstration services may be directed by a legal representative of the participant.
	X	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities), available for each demonstration service. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Personal Care	X	X
Respite Care	X	X
Companion Care	X	X
Adult Day	<input type="checkbox"/>	X
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

X	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-j). Specify whether governmental and/or private entities furnish these services. Check each that applies:</i>
<input checked="" type="checkbox"/>	Governmental entities
<input type="checkbox"/>	Private entities
O	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

O	FMS are covered as a Demonstration service	Fill out i. through iv. below:
X	FMS are provided as an administrative activity. Fill out i. through iv. below:	
	i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: Participants enrolled in consumer or surrogate directed care as well as Flexible Choices must use the Fiscal Intermediary Services Organization (ISO). Fiscal ISO is paid by Vermont Medicaid for actual costs. The ISO will be used for the MFP demonstration if the participant chooses consumer or surrogate directed care as well as Flexible Choices.
	ii.	Payment for FMS. Specify how FMS entities are compensated for the activities that they perform: In all of DAIL's self-directed programs, all expenses incurred by participants are billed through the Fiscal Intermediary Services Organization (ISO). The

	ISO assists the participant and/or representative to manage and distribute funds contained in their budget to include but not limited to: payroll including federal, state and local tax withholdings/payments; unemployment compensation fees, making payments for goods and services; fiscal accounting and expenditure reports. The ISO is required to be utilized by the participant and/or representative that chose to use consumer or surrogate directed services as well as Flexible Choices.																												
iii.	<p>Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):</p> <p><i>Supports furnished when the participant is the employer of direct support workers:</i></p> <table border="1"> <tr> <td>X</td> <td>Assist participant in verifying support worker citizenship status</td> </tr> <tr> <td>X</td> <td>Collect and process timesheets of support workers</td> </tr> <tr> <td>X</td> <td>Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</td> </tr> <tr> <td></td> <td>Other (<i>specify</i>):</td> </tr> <tr> <td></td> <td></td> </tr> </table> <p><i>Supports furnished when the participant exercises budget authority:</i></p> <table border="1"> <tr> <td>X</td> <td>Maintain a separate account for each participant's self-directed budget</td> </tr> <tr> <td>X</td> <td>Track and report participant funds, disbursements and the balance-of participant funds</td> </tr> <tr> <td>X</td> <td>Process and pay invoices for goods and services approved in the service plan</td> </tr> <tr> <td>X</td> <td>Provide participant with periodic reports of expenditures and the status of the self-directed budget</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Other services and supports (<i>specify</i>):</td> </tr> <tr> <td></td> <td></td> </tr> </table> <p><i>Additional functions/activities:</i></p> <table border="1"> <tr> <td>X</td> <td>Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</td> </tr> <tr> <td>X</td> <td>Other (<i>specify</i>):</td> </tr> <tr> <td></td> <td>Run background checks on all workers as required by DAIL and disqualify workers who fail to meet the background check standards</td> </tr> </table>	X	Assist participant in verifying support worker citizenship status	X	Collect and process timesheets of support workers	X	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance		Other (<i>specify</i>):			X	Maintain a separate account for each participant's self-directed budget	X	Track and report participant funds, disbursements and the balance-of participant funds	X	Process and pay invoices for goods and services approved in the service plan	X	Provide participant with periodic reports of expenditures and the status of the self-directed budget	<input type="checkbox"/>	Other services and supports (<i>specify</i>):			X	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	X	Other (<i>specify</i>):		Run background checks on all workers as required by DAIL and disqualify workers who fail to meet the background check standards
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<input type="checkbox"/>	Other services and supports (<i>specify</i>):																												
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X	Other (<i>specify</i>):																												
	Run background checks on all workers as required by DAIL and disqualify workers who fail to meet the background check standards																												
iv.	<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p> <p>The ISO serves as an agent of the State and is responsible for submitting the State of Vermont monthly report of the funds and expenditures under their control. The State meets monthly with the ISO to review their activities. The ISO also is sends monthly statements of expenditures to individual</p>																												

participants. DAIL is responsible for monitoring the ISO.

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input checked="" type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i></p> <p>Case Managers assist participants enrolled in Surrogate and Consumer Directed services and Consultants assist participants in Flexible Choices. Both Case Managers and Consultants certify an individual or surrogate as an “employer”, train the participant, develop the service plan or budget and support the participant to be involved in the planning process. The case managers and consultants supply the participants will a list of qualified providers and services that can be self directed. They also monitor the services and make changes to the service plan as needed. Case Managers and Consultants also:</p> <ul style="list-style-type: none"> • assure that the participant has in place an emergency back-up plan; • assess the adequacy of care being provided; • reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services; and • reporting suspected cases of Medicaid Fraud to the State Medicaid Fraud Unit.
<input checked="" type="checkbox"/>	<p>Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:</p>
<input type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p>
	<p>Case management</p>

k. **Independent Advocacy** (*select one*).

<input checked="" type="checkbox"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p>
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	Independent advocacy is available through the AAAs, ARDCs, CILs/SCILs, Office of the Ombudsman, Flexible Choices consultants to participants. They can access any of these agencies by contacting the local office.
<input type="radio"/>	No. Arrangements have not been made for independent advocacy.

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants in either program may voluntarily terminate self-direction in order to receive services through an alternate service delivery method, such as a traditional provider. To accommodate this, the case manager or consultant will educate the enrollee on giving adequate notice to their worker so that alternative arrangements can be made. This may take up to two weeks if necessary and will provide the consultant or case manager the necessary time to follow standard procedures to switch the service(s) from self-direction to an alternative service delivery method.

When voluntary switches occur, the participant and/or guardian contacts the consultant or case manager, who coordinates services with a waiver- enrolled provider agency, selected by the participant, and then updates the service plan to reflect the services that have been modified. A copy of the revised service plan is then given to the participant. The consultant or case manager, through contact with service providers and follow-up calls to the participant, assures that services are in place. He/she continues to monitor the health and welfare of the participant during the transition through phone calls, in-person visits, running late or missed visit reports, and re-assessing the participant as necessary.

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The participant may be involuntarily switched from SD, CD or Flexible Choices options to provider-managed services for any of (but not limited to) the following reasons: 1) participant is not able to manage the requirements of being an "employer" or the requirements of the Flexible Choices Program; 2) the participant or surrogate commits fraud or otherwise inappropriately uses their resources; or 3) the participant's health, safety or welfare is at risk for any reason. (Participants who 1) become no longer eligible for Choices for Care or 2) die will be involuntarily removed from one of the self-directed options but will not be transferred to another Choices for Care option.) The consultant or case manager plans and implements the return of the participant to provider-managed services as well as reports any health, safety, fraud, or abuse concerns to the appropriate state agencies. The final determination in all cases of involuntary disenrollment is made by the case management or consultant agency.

Participants who are involuntarily disenrolled from SD, CD or Flexible Choices, but are still

eligible for CFC, will have a new care plan developed for an expeditious and safe transfer to another CFC option. It will be developed for them by the consultant or case manager working with them. As is the case with voluntary termination, the consultant or case manager, through contact with service providers and follow-up calls to the participant, assures that services are in place. He/she continues to monitor the health and welfare of the participant during the transition through phone calls, in-person visits, running late or missed visit reports, and re-assessing the participant as necessary. Any suspected cases of abuse, neglect, exploitation are reported to Adult Protective Services.

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
Year 1	5	3
Year 2	6	3
Year 3	7	3
Year 4	8	4
Year 5	9	4

Participant Employer

a. **Participant – Employer Authority** (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

1. **Participant Employer Status.** Specify the participant's employer status under the demonstration. Check each that applies:

<input type="checkbox"/>	<p>Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:</p>
<input checked="" type="checkbox"/>	<p>Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

2. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

X	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated: The costs of background checks are considered part of the administrative costs for an agency or provider, and are part of the contract for services of an ISO.
X	Specify additional staff qualifications based on participant needs and preferences
X	Determine staff duties consistent with the service specifications
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)

<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

b. Participant – Budget Authority (Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)

1. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

X	Reallocate funds among services included in the budget
X	Determine the amount paid for services within the State's established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications
X	Specify how services are provided,
X	Identify service providers and refer for provider enrollment
X	Authorize payment for demonstration goods and services
X	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (specify):

2. **Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participant Goals and Budget Development: The budgeting process is person centered and begins with the participants' identifying goals for their maintaining or enhancing their health, well-being and independence at home that they want to meet using their allowance. These goals guide not only the budget development process but also the monitoring and evaluation process. Budgets are agreed upon by the consultant and the participant after an assessment of personal care, respite care, adult day and companion care needs is performed.

Either the participant or the consultant may consult with DAIL staff if they have questions or if they feel that they need assistance from a third party to resolve difficult issues. The allowance is the number of dollars the individual has available to them to pay for their care. The allowance is calculated on the basis of a two-week allocation.

The allowance amount is derived from the individual's current Service Plan. If the participant's needs have changed since his or her most recent assessment, the consultant will complete a

new assessment and the allowance will be based on that assessment.

Specific allowance amounts will be derived from three components: a base amount which will be the same for all participants, a personal care amount and an adult day amount. Allowance amounts are approved by the Long Term Care Clinical Coordinator.

3. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Budgets are agreed upon by the consultant and the participant. Either the participant or the consultant may consult with DAIL staff if they have questions or if they feel that they need assistance from a third party to resolve difficult issues. Requests for additional adjustments in the budget amount are directed by the consultant to the LTCCC.

4. **Participant Exercise of Budget Flexibility. Select one:**

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input checked="" type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

5. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Participants receive a financial statement from the Fiscal ISO after each payroll. This includes a beginning and ending balance and an itemized listing of all expenditures during that pay period. It also includes current accrued savings. A copy of this report also goes to the consultant. The ISO monitors expenditures and notifies the participant and consultant when spending exceeds budgeted amounts. All charges, except consultant and Fiscal ISO fees, require the participant's signature. The Fiscal ISO informs the participant via telephone whenever they have to pull money from other budget items to cover payroll. They inform the consultant if there appears to be a pattern with the participant's being unable to manage his/her care within the budgeted amount. The consultant also reviews the bi-weekly financial statement to assure that the participant's plan is being properly implemented. Consultants must contact participants weekly for the first month and monthly throughout their period of participation in Flexible Choices.

That monthly contact will include:

- a) Review and update, if appropriate, of the participant's goals ;
- b) Review of the budget including budget expenditures;
- c) Ascertaining the participant's perception of their wellbeing; and
- d) Discussion of any problems or concerns perceived by the consultant

APPENDIX H
DRAFT INCIDENT REPORT FORM

APPENDIX H

**DIVISION OF DISABILITY AND AGING SERVICES
DEPARTMENT OF DISABILITIES, AGING & INDEPENDENT LIVING CRITICAL INCIDENT REPORT**

DAIL
103 South Main Street
Waterbury, VT 05671-1601
Phone: Fax:

Please print	
Name of Person: _____	Date of birth ____/____/____
Agency: _____	
Guardian: _____	Public ___ Private
Individual Reporting: _____	Title: _____

Date of Critical Incident: ____/____/____ **Time:** _____

Type of Incident – Check all that Apply:

- Death (Call 1-802-353-8276, if no answer 1-800-642-3100 immediately)
- Missing person (Call 1-802-353-8276, if no answer 1-800-642-3100 immediately)
- Suspected abuse, neglect, exploitation: ___ of person ___ by person
- *Call 1-800-564-1612 Adult Protective Services, to report abuse of an adult*
- Serious injury/medical condition requiring treatment by a physician
- Medication error requiring treatment by a physician
- Criminal act by a person who receives services
- Criminal act by staff/worker
- Use of a restraint
- Unexpected hospitalization
- Other critical incidents such as fire, theft or destruction of property, criminal act or unusual events (please specify here) _____

Who Was Notified About This Incident?

- Case Manager Guardian MFP Project Director APS MFP Quality Specialist
- Other (please specify) _____

APPENDIX H

Description of Incident:

Review completed by: ___ Case Manager **and** ___ Quality Management Specialist

Case Manager Name: _____ Phone #: _____ Date: _____

Quality Management Specialist Name: _____

Phone#: _____ Date: _____

Action Taken:

Is follow-up needed? ___ Yes ___ No (if yes, please describe the follow-up activities and who is performing them)

Date Report was closed: _____

Date Report was reviewed by DAIL QM Committee: _____

APPENDIX I
PROJECT DIRECTOR JOB DESCRIPTION

Vermont MFP Demonstration Program**Position Title:** Project Director**Main functions:**

The Project Director will be responsible for leading the design, development, implementation, and plans for sustaining the CMS MFP demonstration.

Reports to: Department of Disability, Aging and Independent Living (DAIL) Commissioner**Duties:**

- Hire personnel for program implementation
- Responsible for overall quality and management of MFP program
- Oversees budget and ensure financial accountability
- Supervise program delivery
- Recognize and solve potential problems and evaluate program effectiveness
- Ensure operating procedures meet program goals
- Provide program content expertise
- Facilitate MFP Steering Committee Meetings
- Facilitate ad-hoc workgroups and forums
- Address capacity issues as they arise
- Perform quality functions
- Network with local, state and national agencies for future program development as required.

To perform this job successfully, an individual must be able to perform each duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required.

- Excellent supervisory, organizational and training skills
- Experience in program development and implementation
- Experience in coordinating activities, evaluating data, and establishing priorities
- Excellent communication and presentation skills
- Ability to analyze problems and make well-reasoned, sound decisions
- Related grant experience

EDUCATION and/or EXPERIENCE:

Master's Degree Required

APPENDIX J
MFP MAINTENANCE OF EFFORT FORMS

Maintenance of Effort (MOE) Form
Money Follows the Person Demonstration Grant Program (Nov 2010)

STATE:	VT	Grant #:	CMS-1LI-11-001
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Reporting Year Format: State Fiscal Year (Fiscal YEAR RUNS: July 1-June 30)
 FEDERAL FISCAL YEAR _____ Calendar Year _____

Total State Expenditures for Home & Community-based Services

Base Year					
	2007	2008	2009	2010	2011
				\$16,669,774	

State Share					
2012	2013	2014	2015	2016	2017

2018	2019

Attestation (required by Section 6071 of the Deficit Reduction Act of 2005)

I assert by my signature that the expenditure report above is accurate and follows the MFP MOE Form instructions. I also assert that all qualified HCBS programs operating under a waiver under section (d) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

Signature :	<i>William R. Kelly</i>	Date:	<i>3/24/11</i>
Title/Position:	<i>Financial Services Director</i>		

Instructions

1. Fill out your State and Official Grant Number.
2. Check off the Report year you will be using. If it is the State Fiscal Year, indicate the dates of the year the report covers. You must report by either State FY, Federal FY or Calendar year.
3. Fill in each year's expenditures for HCBS starting with the base year which you will fill in. The base year is the immediate previous full year of expenditures based on the reporting year format you have chosen. For new applicants for 2011 provide only your base year. For existing grantees only provide the base year and the first full year you began your grant through the latest reporting period.
4. Medicaid HCBS Expenditures include all non-institutional services and include waiver and HCBS State plan services such as personal care services, rehab services and other State plan services you cover that are non-institutional.
5. The State authorized signatory must sign and date as well as identify their Title or position as indicated. The second element to attest to is the continuation of meeting cost neutrality in the waivers your State provides.

APPENDIX K
SUB APPENDIX IV – WORKSHEET FOR PROPOSED BUDGET

APPENDIX K

Money Follows the Person Demonstration Worksheet for Proposed Budget (revised March 31, 2011)

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will autopopulate. Please **DO NOT** alter any formulas.
Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates.

Date of Report: 3/29/2011		Please express FMAP as a decimal. (example: 68.32%=.6832)				
Name of State/Grantee: Department of Vermont Health Access (DVHA)		State FMAP (Hold Harmless Rate Oct 2008 - Dec 2010)	State Enhanced FMAP	Increased FMAP (Oct 2009 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP (Oct 2008 - Dec 2010)
Grant #:		FFY 2007		0.50000		0.50000
CMS-IL1-11-001		FFY 2008		0.50000		0.50000
Demonstration Program Title: Money Follows the Person Rebalancing Grant Demonstration	10-12/2008	FFY 2009 Q1		0.50000		0.50000
	1-3/2009	FFY 2009 Q2		0.50000		0.50000
	4-6/2009	FFY 2009 Q3		0.50000		0.50000
	7-9/2009	FFY 2009 Q4		0.50000		0.50000
	10-12/2009	FFY 2010 Q1		0.50000		0.50000
	1-3/2010	FFY 2010 Q2		0.50000		0.50000
	4-6/2010	FFY 2010 Q3		0.50000		0.50000
	7-9/2010	FFY 2010 Q4		0.50000		0.50000
	10-12/2010	FFY 2011 Q1		0.50000		0.50000
	1-3/2011	FFY 2011 Q2		0.50000		0.50000
	4-6/2011	FFY 2011 Q3	0.5871	0.79355	0.65240	0.82620
	7-12/2011	FFY 2011 Q4	0.5871	0.79355		0.79355
		FFY 2012	0.5758	0.78790		0.78790
		FFY 2013	0.5758	0.78790		0.78790
		FFY 2014	0.5758	0.78790		0.78790
		FFY 2015	0.5758	0.78790		0.78790
	FFY 2016	0.5758	0.78790		0.78790	

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Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.
All population counts and budget estimates are based on the *Calendar Year (CY)*.

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total per CY
CY 2007						0
CY 2008						0
CY 2009						0
CY 2010						0
CY 2011	23		2			25
CY 2012	60		10			70
CY 2013	65		10			75
CY 2014	73		12			85
CY 2015	77		13			90
CY 2016	26		4			30
Total Count	324	0	51	0	0	
				Total of Populations	375	

Demonstration Budget Summary

Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services are defined in the RFP.

Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7); *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); *Administrative - Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).

Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	Rate	Total Costs	Federal	State
Qualified HCBS		\$ 16,178,754	\$ 12,758,381	\$ 3,420,373
Demonstration HCBS		\$ 885,413	\$ 698,368	\$ 187,044
Supplemental		\$ -	\$ -	\$ -
Administrative - Normal		\$ -	\$ -	\$ -
Administrative - 75%		\$ -	\$ -	\$ -
Administrative - 90%		\$ -	\$ -	\$ -
Federal Evaluation Supports		\$ 37,500	\$ 37,500	\$ -
Administrative (Other) - 100%		\$ 3,838,371	\$ 3,838,371	\$ -
State Evaluation		\$ -	\$ -	\$ -
Total		\$ 20,940,037	\$ 17,332,620	\$ 3,607,417

Per Capita Service Costs	\$ 45,504
Per Capita Admin Costs	\$ 10,236

Rebalancing Fund Calculation	
CY 2007	\$ -
CY 2008	\$ -
CY 2009	\$ -
CY 2010	\$ -
CY 2011	\$ 243,458
CY 2012	\$ 492,723
CY 2013	\$ 574,336
CY 2014	\$ 664,985
CY 2015	\$ 765,578
CY 2016	\$ 877,091
Rebalancing Fund Total	\$ 3,618,171

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CY 2007	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.50000	\$ -	\$ -	\$ -	Grant Funding for CY 2007 \$ -
Demonstration HCBS	0.50000	\$ -	\$ -	\$ -	Total Fed Costs \$ -
Supplemental	0.00000	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year \$ -
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ -
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -	
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ -	\$ -	\$ -	

CY 2008 (including Partial Year Increased FMAP)	Rate	Total Costs	Federal	State	Summary
Qualified HCBS (Jan - Sept)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding \$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs \$ -
Demonstration HCBS (Jan - Sept)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year \$ -
Supplemental (Jan - Sept)	0.00000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ -
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -	
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -	
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ -	\$ -	\$ -	

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CY 2009 (using Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Qualified HCBS (Jul- Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Demonstration HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Jul Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Jul- Sep increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

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CY 2010 (using increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Qualified HCBS (Jul-Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Qualified HCBS (Oct-Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 1,516,762
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 1,516,762
Demonstration HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Jul-Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Oct-Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Jul-Sep increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Oct-Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

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CY 2011 (using partial year increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ 1,516,762
Qualified HCBS (Apr-Jun increased FMAP)	0.82620	\$ 154,276	\$ 127,463	\$ 26,813	Total Fed Costs	\$ 1,516,762
Qualified HCBS (Jul-Dec)	0.79355	\$ 926,025	\$ 734,847	\$ 191,178	Balance (Carry Over)	\$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 2,548,653
Demonstration HCBS (Apr-Jun increased FMAP)	0.82620	\$ 10,413	\$ 8,603	\$ 1,810	Total (Balance + Request)	\$ 2,548,653
Demonstration HCBS (Jul-Dec)	0.79355	\$ 62,500	\$ 49,597	\$ 12,903		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.65240	\$ -	\$ -	\$ -		
Supplemental (Jul-Dec)	0.58710	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 5,000	\$ 5,000	\$ -		
Administrative (Other) - 100%	1.00000	\$ 591,253	\$ 591,253	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,749,466	\$ 1,516,762	\$ 232,704		

CY 2012	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.78790	\$ 2,185,567	\$ 1,722,008	\$ 463,559	Remaining Award Funding	\$ 2,548,653
Demonstration HCBS	0.78790	\$ 137,500	\$ 108,336	\$ 29,164	Total Fed Costs	\$ 2,548,653
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 2,874,058
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 2,874,058
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 5,500	\$ 5,500	\$ -		
Administrative (Other) - 100%	1.00000	\$ 712,808	\$ 712,808	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 3,041,375	\$ 2,548,653	\$ 492,723		

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CY 2013	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78790	\$ 2,557,856	\$ 2,015,334	\$ 542,521	Remaining Award Funding \$ 2,874,058
Demonstration HCBS	0.78790	\$ 150,000	\$ 118,185	\$ 31,815	Total Fed Costs \$ 2,874,058
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year \$ 3,231,662
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 3,231,662
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ 6,000	\$ 6,000	\$ -	
Administrative (Other) - 100%	1.00000	\$ 734,539	\$ 734,539	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 3,448,395	\$ 2,874,058	\$ 574,336	

CY 2014	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78790	\$ 2,972,745	\$ 2,342,226	\$ 630,519	Remaining Award Funding \$ 3,231,662
Demonstration HCBS	0.78790	\$ 162,500	\$ 128,034	\$ 34,466	Total Fed Costs \$ 3,231,662
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year \$ 3,627,509
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 3,627,509
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ 6,500	\$ 6,500	\$ -	
Administrative (Other) - 100%	1.00000	\$ 754,903	\$ 754,903	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 3,896,648	\$ 3,231,662	\$ 664,985	

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CY 2015	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78790	\$ 3,434,516	\$ 2,706,055	\$ 728,461	Remaining Award Funding \$ 3,627,509
Demonstration HCBS	0.78790	\$ 175,000	\$ 137,883	\$ 37,118	Total Fed Costs \$ 3,627,509
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year \$ 3,533,975
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 3,533,975
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ 7,000	\$ 7,000	\$ -	
Administrative (Other) - 100%	1.00000	\$ 776,572	\$ 776,572	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 4,393,088	\$ 3,627,509	\$ 765,578	

CY 2016	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78790	\$ 3,947,770	\$ 3,110,448	\$ 837,322	Remaining Award Funding \$ 3,533,975
Demonstration HCBS	0.78790	\$ 187,500	\$ 147,731	\$ 39,769	Total Fed Costs \$ 3,533,975
Supplemental	0.57580	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ -
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ 7,500	\$ 7,500	\$ -	
Administrative (Other) - 100%	1.00000	\$ 268,296	\$ 268,296	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 4,411,066	\$ 3,533,975	\$ 877,091	

Money Follows the Person (MFP)

Submission to Joint Fiscal Office

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U.S. DHHS Money follows the Person News Release Related to Vermont Grant

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Vermont MFP Rebalancing Demonstration Operational Protocol
Revised Operational Protocol Draft with tracked changes submitted for
approval from Centers for Medicare and Medicaid Services

Vermont MFP Rebalancing Demonstration Appendices

Vermont Specific Terms and Conditions with Responses

MFP Frequently Asked Questions and Answers

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Position Request Form

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