Promising Practices in Long Term Care Systems Reform: Vermont's Home and Community Based Service System

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Vermont's Home and Community Based Service System

As home and community based support systems continue to grow and evolve, states are examining whether their current systems reflect fundamental participant and community values. A number of states are concluding that they need to put in place systemic reforms to ensure that their home and community-based support systems promote dignity, independence, individual responsibility, choice, and self-direction.

Systemic reforms simultaneously address multiple aspects of community long term support systems in order to improve responsiveness to participants' needs and preferences. These initiatives are developing entirely new ways of designing, organizing, and managing community based supports as a system rather than as a random collection of uncoordinated individual services. In some cases, this has required states to make fundamental changes to the administrative infrastructure of their home and community-based support programs.

Two design features in particular have repeatedly emerged as essential components of systemic reform initiatives:

- *Community Access Points*, which provide persons with a clearly identifiable place to get information, advice and access to a wide variety of community supports.
- *Person-Centered Services*, which place participants, not services or providers, as the central focus of funding and service planning.

The Centers for Medicare and Medicaid Services contracted with Medstat to examine approaches nine states took to developing Community Entry Points and Person-Centered Services to assist older people and people with disabilities live productive and full lives in integrated community settings. We conducted on-site interviews with state officials, advocacy organizations and local program administrators and extensively reviewed written documents on policy proposals, administrative rules, and program evaluations. The emphasis of the resulting nine case study reports is on identifying transferable models that can be adapted for replication in other states and communities across the country, while acknowledging that some aspects of state systems may be unique to each state's culture, history, and traditions.

Since most states have separate service delivery systems for different populations, each case study will focus on a particular population. In Vermont, our focus is on long term supports for older persons and adults with physical disabilities.

Overview of Vermont's Home and Community-Based Services System

Several years ago Vermont mounted a multiyear effort to increase the proportion of its long term care spending devoted to home and community-based services. This initiative was triggered by a 1996 law that called for shifting the balance of the state's long term care spending by reducing the rate of growth for Medicaid nursing home expenditures and investing the savings in home and community based supports. Act 160 established specific

targets for the level of savings to be achieved in each of the four years following its enactment. Advocacy organizations, providers, officials of the Department of Aging and Disabilities, and key state legislators joined forces to achieve passage of this landmark legislation.

The state was successful. In just six years, the share of the state's long term care expenditures devoted to nursing facility services decreased from 88 percent in 1996 to 75 percent in 2002. In the process, Vermont significantly expanded community based options, including new residential services, and offered greater opportunities for participants to self-direct their supports.

For each of the four years that Act 160's rebalancing benchmarks were in effect, the Vermont Department of Aging and Disabilities was charged with developing a budget proposal that presented recommendations for increased investments in community supports. Using the colloquially called "Act 160 Funds" generated from reducing the projected growth of institutional spending, existing programs were expanded and one-time only awards were made to enhance the capability of particular provider types. In addition, Flexible Funds were awarded annually to local long term care coalitions to fill gaps and test out new program concepts. Although the four year period of mandatory reinvestment has ended, the state has continued to support significant increases in home and community based service programs.

Key features of Vermont's major home and community based services programs for older people and adults with physical disabilities are highlighted below.

The Home-Based Medicaid 1915(c) Waiver Program provides supports to older people and adults with physical disabilities who meet the state's eligibility criteria for Medicaid-financed long term care services and are assessed as a priority for program admission. The largest of all the community-based programs administered by the Department of Aging and Disabilities, it provides supports to people living in their own homes, including personal care (participant and surrogate directed attendant care and agency provided personal care), respite, companion services, adult day services, personal emergency response systems, assistive devices and home modifications.

The Enhanced Residential Care Medicaid 1915(c) Waiver Program serves persons who meet the same eligibility criteria established for the Home-Based Waiver and choose to live in residential care homes or assisted living facilities. The service of enhanced residential care includes case management, health assessment, monitoring and routine nursing tasks, assistance with activities of daily living, medication management, social and recreational activities, oversight of persons with dementia, 24-hour on-site supervision, laundry and household services,

The Traumatic Brain Injury Waiver is targeted to individuals 16 years and older with a recently acquired brain injury who have a demonstrated potential to benefit from rehabilitation services and would otherwise require treatment in an out-of-state rehabilitation facility. Services include case management, rehabilitation, transitional living, respite and assistive technology.

The Attendant Services Program serves adults of all ages with disabilities who need assistance with daily activities. It has four separate components:

- **General Fund Participant-Directed Attendant Care** is targeted to people who have a permanent and severe physical disability and need assistance with at least two activities of daily living. Program participants hire, train and schedule their attendant provider. A participant may employ his/her spouse or Civil Union partner as an attendant.

- **Medicaid Participant-Directed Attendant Care** is essentially the same service as general fund participant-directed attendant care, available under the Medicaid state plan to people who meet regular Medicaid financial eligibility criteria and are determined capable of directing their own care. Spouses and Civil Union partners may not be hired as care attendants under this component.

- **General Fund Personal Services** supports people who have a disability and need assistance with at least one activity of daily living or with meal preparation and are Medicaid eligible. Participants may appoint an agent to direct their supports if they do not want to do it themselves. A participant may employ his/her spouse or Civil Union partner as an attendant.

- **Group-Directed Attendant Care** supports individuals who have a permanent and severe disability, need attendant services for at least two activities of daily living, need four or more hours of attendant services daily, live with other eligible individuals in a group living situation approved by the Department, and are capable of directing their supports. Currently no group-directed attendant care programs are in place. However, if state general revenue funds become available for this purpose, rules guiding implementation of this service option are already on the books.

The Adult Day Program provides health assessment, screening and monitoring, therapies, personal care, and nursing services. It is funded as a distinct program through state general revenues/Social Services Block Grant funds and the Medicaid state plan. People who receive support through these funding sources are either financially or functionally ineligible for the state's Medicaid waiver programs. Adult day services are also covered by the Home-Based waiver program.

The Homemaker Program serves older people and adults with disabilities who need assistance with one or more activities of daily living and/or have a cognitive impairment. Funded through state general revenues and Social Services Block Grant funds, it provides home care services and home management services such as cooking, cleaning, laundry, and other housework. The meaning of "home care services" is quite flexible. According to the statute, it "…means professional or personal services, including homemaker services, required on a recurring or continuous basis by an individual because of physical or mental impairment."

The Housing and Supportive Services (HASS) Program uses state general revenues to coordinate access to existing community services for older people and adults with physical disabilities living in congregate housing settings. Besides service coordination, program funds can be used as a last resort to finance supports otherwise unavailable for residents who are at the greatest risk of nursing home admission.

Vermont's fiscal year 2002 long term care program expenditures and the number of participants served by each is presented in the following table. In reviewing the data, it is important to keep in mind that Vermont is a very small state with 608,827 residents, ranking 49th in population among all states.

2002 Vermont Long Term Care Expenditures and Recipients: Older People and Adults with Physical Disabilities

Programs	Expenditures	Participants
Home-Based HCBS Medicaid Waiver	$19,317,506	1,315
Enhanced Residential Care HCBS Medicaid Waiver	$1,770,393	199
Traumatic Brain Injury HCBS Medicaid Waiver	$2,059,814	35
Attendant Services Program - General Fund	$3,448,283	186
Attendant Services - Medicaid State Plan	*$181,364	83
Adult Day Services - General Fund & SSBG	$1,038,786	397
Adult Day Services - Medicaid State Plan	$841,442	162
Homemaker - General Fund & SSBG	$801,471	851
Housing and Supportive Services	$550,000	713
Medicaid Nursing Home Services	$90,552,604	2,073
Total:	$120,561,663	

Source: Vermont Department of Aging and Disabilities * partial year start-up

The Department of Aging and Disabilities manages and regulates the full range of publicly funded community-based and institutional services targeted to older people and adults with physical disabilities. With this broad scope of authority, it is not surprising that it was designated as the lead executive branch department to spearhead a shift in the balance of public long term care funding between nursing facilities and home and community-based services.

The Department has worked closely with program participants, organizations that advocate on their behalf, and the full range of providers of long term supports to design Vermont's home and community based service system. At the state level, stakeholders actively participated in drawing up the reform plan. Locally through their membership in one of ten long term care coalitions established throughout the state, advocates and providers continue to collaborate on

identifying ways to improve service capacity, options, and coordination in their geographic areas.

The long term care coalitions, which operate in areas generally corresponding to the state's county boundaries, have also been given the authority by the Department of Aging and Disabilities to select either the area agency on aging or the home health agency to coordinate management of the Home-Based and Enhanced Residential Care waiver programs in their regions. These Designated Administrative Agencies manage the application process for individuals seeking waiver services, maintain waiting lists, coordinate the activities of the interagency Medicaid waiver team, and maintain program and enrollee data. These functions are supported by Medicaid administrative funds. Area agencies on aging are the Designated Administrative Agencies in five regions and in the others, home health agencies perform these functions.

Case management is funded as a service under Vermont's Medicaid waiver programs rather than as an administrative function. Participants can receive case management services from any agency determined by the Commissioner to be an eligible provider. Currently each region has two case management agencies: an area agency on aging and a home health agency. Medicaid waiver teams in each region prioritize individual applications for enrollment in home and community based service waiver programs. Waiver team membership includes case managers employed by area agencies on aging and home health agencies, as well as staff of service provider agencies. The extensive involvement of staff from multiple agencies in reviewing participant assessments and service plans creates a locally based system of checks and balances to ensure that participants receive complete information about all service options and that the freedom of choice requirements of the Medicaid program are upheld.

This statewide network provides the foundation for Vermont's community based long term care programs. The result is a system characterized by collaboration among key agencies, advocates, and other stakeholders. It is built upon the principle of maximizing participant choice of services, providers and living arrangements. To meet emerging participant needs and preferences Vermont, significantly expanded the capacity of its existing programs and created new ones as savings materialized from reductions in projected nursing home spending.

Although this case study focuses on Vermont's long term care system for older persons and adults with physical disabilities, the state has also created comprehensive community based service systems for persons with developmental disabilities and mental health needs. The Department of Developmental and Mental Health Services administers a Medicaid 1915(c) waiver program that supports persons with developmental disabilities to live in independent settings or in residential settings of one or two persons. An 1115 Waiver administered by the same department serves the chronically and persistently mentally ill through a network of community mental health agencies.

To provide a complete picture of the strategies Vermont employed to redirect funding and services from nursing homes to home and community based programs, this report highlights the historical evolution of the state's long term care system and the critical role stakeholders

played in defining the system's guiding principles, shaping its initial design, and guiding ongoing policy development. This report also presents an in-depth description of the essential components of Vermont's service delivery system along with lessons other states can gain from its experiences.

Evolution of Vermont's Home and Community-Based Service System

Enabling people to live in the setting of their choice and empowering them to direct their own supports have been guiding principles formally articulated by administrators, legislators, advocates and participants in Vermont for almost two decades. However, translating those principles into concrete policies accompanied by investments of public resources has been a continual journey. Like other states that have achieved comprehensive reform of their long term care systems, progress in Vermont has been in part incremental and in part stimulated by major initiatives that triggered dramatic changes.

Laying the Groundwork: State Policy Reports

In the 1980's two study commissions led by Vermont publicly elected officials proposed redesigning the state's long term care system by expanding community based services. At the time, the state's only available services were Medicaid funded nursing home care, federally funded Older Americans Act programs and a relatively small state funded attendant services program. One set of recommendations emerged from a 1986 report of the state legislature; similar issues were addressed by a 1988 commission lead by the Lieutenant Governor. Together these two studies provided the impetus for initiation in 1988 of a Home-Based HCBS Medicaid waiver program and state funding for adult day services and homemaker services.

The studies also called for the development of a comprehensive long term care delivery system, which began with the creation of a new state department that would consolidate all of the state's long term care policy, program and regulatory functions. The Department of Aging and Disabilities was established in 1989 to administer the state's home and community based services programs for older people and adults with physical disabilities, nursing home and residential services, Older Americans Act programs, vocational rehabilitation, and long term care provider licensing and certification.

The Department, in turn, issued a 1991 report, *Long Term Care in Vermont*, that examined the balance between institutional services and home and community based supports. The report's key recommendation was that the state spend at least 30 percent of all public long term care funds for community based services. State officials started looking at what would be needed to achieve such a sea-change in Vermont's policies. In the process it successfully competed for a grant from the U.S. Administration on Aging to plan for a Community Assisted Independent Living System. A key aspect of this effort was convening long term care coalitions at the state and local levels consisting of a broad range of stakeholders such as older persons, people with disabilities, and service providers, charged with identifying ways to improve the long term care system.

One of the leading solutions to emerge was the creation of regional service centers to be single entry points where individuals would gain access to needs assessment, services, and on going case management. In the end, this proposal was rejected due to heated disagreements about which agencies would become the designated regional service centers and lack of funding to support inclusion of younger adults with disabilities. However, the stakeholder coalitions endured and became critical elements of the state's next long term care reform initiative.

Events converged to refocus reform efforts on the guiding principle that had gained prominence in the state during the early 1990's—shifting the balance of long term care spending to increase home and community based services. As state officials assessed their previous reform initiative, they concluded that focusing on the delivery system infrastructure had diverted attention away from the real goal. Re-aligning long term care financing proved to be a timely issue, capturing the attention of state legislators who were grappling with a budget crisis.

The Department formed a coalition of legislators, disability and aging advocates, providers, and other state officials to craft a plan for constraining the growth of Medicaid nursing home expenditures and investing the savings in community based services. Adding weight to the initiative was the Health Care Allocation Plan issued by the Department of Banking, Insurance, Securities and Health Care Administration that concluded Vermont had an oversupply of nursing homes and recommended a moratorium on the issuance of new certificates of need. By the time the coalition's reform plan was introduced during the 1996 session of the state legislature, it had the overwhelming support of the aging and disability communities, as well as state officials, and was enacted.

Shifting the Spending Balance: Act 160

Act 160 articulates a framework for Vermont's long term care policies that continues to guide the state's approach to providing supports to older people and adults with physical disabilities. Its primary goals are to:

- Improve the state's independent living options for vulnerable elders and younger people with disabilities
- Slow the growth of the state's nursing home budget
- Redirect dollars saved to home and community based services, with consumer participation and oversight in the planning and delivery of long term care services.

The legislature established annual targets for reductions in projected Medicaid nursing home expenditures it expected the executive branch to achieve for each of the four years following Act 160's passage. Cumulatively these targets totaled $20 million, a sizable amount within the context of Vermont's long term care budget.

A multifaceted approach to reaching this target was adopted—one that relied on a combination of policies that:

- Gave priority for enrollment in the state's HCBS waiver programs to people at greatest risk of nursing home admission or those who need waiver services to return to the community
- Made strategic investments to expand the array and supply of home and community based services
- Aligned nursing home payment methodologies and certificate of need criteria with the overall policy goal of reducing nursing home utilization.

Prioritizing admissions to HCBS waiver programs—To give preference to people with the most immediate needs, the Department of Aging and Disabilities established a priority order for admission of eligible waiver applicants into the program. In the following order, priority is currently given to:

- Nursing home residents who require waiver services to meet their needs in a home and community based setting
- People in hospitals who will be admitted to a nursing home unless Medicaid waiver services are provided
- People at home or in a residential care home with a score of 25 or above on the Medicaid Waiver Priority Evaluation Form and who will be admitted to a nursing home unless Medicaid waiver services are provided
- Applicants at home or in a residential care home with a score of 20-24 on the Medicaid Waiver Priority Evaluation Form and who will be admitted to a nursing home unless Medicaid Waiver services are provided.

As a result, the Department of Aging and Disabilities began to manage its wait list for waiver programs using measures of individuals' immediate needs rather than their initial application date. Local interagency Medicaid waiver teams meet to review individual waiver applications and assign priority for program admission. The Department believes this process, while time consuming, enhances accountability for the allocation of scarce program resources, supports staff who must make difficult decisions about delaying program admission for people who are assessed as needing a nursing home level of care but have less needs than others, and uses the knowledge local agencies have about each individual.

This prioritization strategy included proactively helping nursing home residents move to the community. Nursing home residents who expressed an interest in relocating were given highest priority in accessing waiver services. Because of this new waiver admission policy, more residents were able to immediately obtain services. During the first 18 months, more than 200 people transitioned from nursing homes to waiver services. After one year, the proportion of persons entering HCBS waivers from either a nursing home or a hospital increased from less than five percent to more than thirty-five percent. Through a grant from the Centers for Medicare and Medicaid Services and the Assistant Secretary for Planning and Evaluation, Vermont obtained funding to continue its proactive nursing home transition activities for another three years.

Strategically investing in home and community based services—Act 160 called for the executive branch to develop an annual budget that presents its recommendations for investing

the savings from reduced nursing home growth into expansion of community based services. Four general types of investments were made.

First, *existing programs that were most directly targeted to persons who would otherwise enter a nursing home were expanded.* Thus, the state's Home-Based HCBS waiver was the recipient of the largest amount of "Act 160 funds", with program expenditures more than doubling during the four year re-investment period. Funding for adult day programs was expanded in three ways. First, the program's base allocation of state general revenues was increased. Second, adult day centers received one-time funding to enhance their capacity to address their participants' increasingly complex health care needs by renovating existing centers, creating satellite sites, and expanding nursing and therapy services. Third, Day Health Services were added in 1999 to the Medicaid state plan, operating in tandem with identical services supported by general revenues and expanding the number of persons who could be served.

Second, *investments were made in new residential supports.* Concurrent with the passage of Act 160, Vermont initiated a new HCBS waiver called the Enhanced Residential Care Program, which provides health-related and personal supports to persons eligible for nursing home care who choose to live in a residential care home.

To help persons who live in congregate housing "age in place," the Department awarded Act 160 funds to two long term care coalitions to pilot a Hope in Housing initiative. Intensive service coordination and supplemental services were introduced into two public housing facilities chosen because a higher proportion of their residents were admitted to nursing homes compared to residents of other housing projects. Since this pilot effort successfully reduced nursing home admissions, the state allocated Act 160 funds to all long term care coalitions to replicate it statewide under a new name, the Housing and Supportive Services (HASS) program. The program now covers 29 housing sites.

Third, *Act 160 funds expanded participant-directed supports.* State general revenues allocated to the Attendant Services Program since 1996 have almost tripled. To further expand the program, in 2002 Vermont added Medicaid Participant-Directed Attendant Care to its Medicaid state plan. As was the case when adult day services were added to the state plan, the new Medicaid attendant service option operates in tandem with the existing general revenue funded service, permitting additional people to be served through the infusion of federal funds.

As part of the evolution of Vermont's home and community based services system, additional options for self-direction were incorporated into its Home-Based Waiver program. In the late 1990's participant-directed and surrogate-directed services were added as optional ways for enrollees to receive personal care services. Now one-half of all personal care hours provided under the Waiver are delivered either to individuals who manage their own supports or have a surrogate undertaking this responsibility.

Fourth, *rates for providers of home and community based services were increased.* Like most other states, Vermont faces a shortage of workers to deliver services. In an attempt to recruit

and retain providers, some of the savings generated from reduced growth in nursing home expenditures have recently been invested in higher wages for participant and surrogate-directed personal care workers for both the Home-Based Waiver and the Attendant Services Program. Payment rates for residential care homes were also increased.

Nursing home payment and supply policies—One component of Vermont's strategy in implementing Act 160 was to create a nursing home reimbursement system and a certificate of need policy that actively promote home and community based services.

In 1998 Vermont took advantage of a sunset provision in its Medicaid nursing home reimbursement rules and devised a new plan that better aligns with the goals set forth in Act 160. Specifically it updated the system used to classify residents' needs to conform with the nationally developed Resource Utilization Groups (RUG) instead of the modified version Vermont had previously used. It also began calculating payments to facilities based only on the acuity level of their Medicaid residents rather than on the case mix of their entire census. Since most non-Medicaid residents required short term rehabilitation, the state determined that their higher needs were inflating case mix scores and thus overstating the cost of serving the population supported by Medicaid. It also eliminated a return on equity allowance.

The state's certificate of need policy for nursing homes flatly states "additional capacity to meet nursing home level of care needs should be met by developing additional community based services including Medicaid waiver services, residential alternatives and adult day programs." Projections of future needs are based on demand for "nursing home level of care," expressed in the number of Medicaid waiver slots that should be added to the state's programs.

Future Directions: Creating Equal Entitlements

Six years after passage of Act 160, Vermont has increased the proportion of its long term care spending devoted to home and community based services from 12 percent to 25 percent. The number of licensed nursing home beds dropped by 12 percent and occupancy rates for the beds that remain fell to an average of 90 percent, down from 98 percent when the balancing initiative began. While it is not possible to conclude which strategies had the greatest effect, state officials are convinced that the entire portfolio of policies was needed to achieve system reforms.

Now the state is embarking on a major new initiative designed to further shift the balance of state long term care spending to community based services, and to do so consistently in each county. To achieve a county utilization target of 40 percent of the individuals using HCBS waiver services and 60 percent using nursing home services paid by Medicaid, Vermont is developing a Section 1115 Medicaid demonstration program that will combine funding for Medicaid HCBS waiver services and nursing home care into a single long-term care budget. Individuals who meet the state's criteria for the "Highest Need Group" would be equally entitled to home and community based services and nursing home care. By providing equal access, the state anticipates that individuals' choices will further shift the balance of spending to the community.

Stakeholder Roles in Program Design and Implementation

Vermont has a long tradition of citizen involvement in policy development. As previously noted, older persons, adults with disabilities, and service providers all played a key role in the state's initial attempt at long term care reform under the Community Assisted Independent Living program. In that effort the Department of Aging and Disabilities awarded funds to the state's five area agencies on aging to convene groups of stakeholders over the course of a year to provide community input into the design of a new long term care system.

When the state went back to the drawing board after its first plan was rejected, stakeholder groups continued to provide community input into the process that led to Act 160. At the state level, a coalition was formed consisting of state legislators, program participants, advocates, and providers. Meeting every two weeks for almost a year, the state coalition hammered out the details of a new plan that was enacted into law by the state legislature.

Act 160 specifically calls for consumer participation in planning and delivering long term care services at the state and local levels. To achieve this, the Department of Aging and Disabilities worked with the state's ten local stakeholder groups to transform them into long term care coalitions. A small amount of Act 160 funds was used to support the coalitions. With these grant awards, they were charged with identifying unmet needs and developing and implementing improvements to their local long term care delivery systems. The coalitions have been widely credited with fostering collaboration among various stakeholders and improving access to services.

For each of the four years following Act 160's passage, long term care coalitions developed business plans that focused on filling local gaps in services or information. These plans were the vehicle used by the Department to allocate state funds to support the coalitions' coordination activities and to award Flexible Funds spent by coalitions on a case by case basis to pay for services not covered by other programs. Their plans also conveyed recommendations for services that the state should either develop or expand statewide with Act 160 savings. As previously noted, the state delegated to the coalitions the authority to select either the area agency on aging or the home health agency as the Designated Administrative Agency to coordinate local management of the two Medicaid HCBS waivers. Currently long term care coalitions oversee the Housing and Supportive Services Program.

Stakeholder participation is also a vital component of the Attendant Services Program. The concepts behind the program's design were advanced by persons with disabilities and were at the leading edge of the independent living movement in the 1980s. One of those concepts vested persons with disabilities with the authority to determine the eligibility of program applicants and to authorize the number of service hours included in each service plan. A committee of program participants has been performing those functions since the program's inception.

At the state level, the Department of Aging and Disabilities collaborates with stakeholders through several vehicles. It meets monthly with its Advisory Board, composed of program

participants, consumer advocates, and community service providers, to obtain guidance and solicit feedback on current programs and pending initiatives. The Department also holds separate monthly meetings with groups of specific agencies, such as area agencies on aging, home health agencies and adult day centers

In addition to these on going efforts, the Department of Aging and Disabilities has entered into a new set of consultations with stakeholders during the past year as it proceeds in developing a Section 1115 Medicaid demonstration proposal to implement a new reform plan. In June 2002 the Department conducted a series of forums throughout the state to solicit stakeholder input into the initial system design. At those forums, the Department invited participants to help flesh out a multitude of program details. The Department then established five stakeholder committees to design policies on eligibility, quality, cashing out benefits, operational protocols, and public education and information. To further solicit public input, the Department posted on its web site a detailed description of its proposed demonstration waiver with an open comment period and mailed the draft waiver application to over 300 individuals for comment.

Community Access Points

Older people and adults with disabilities access Vermont's home and community based services through multiple avenues. Act 160 called for a request for proposal process for authorizing local agencies to administer long term care programs. To implement that provision, the state intended to select one entity per area to be the single entry point for accessing Medicaid waiver programs, handling local program administration and providing case management.

In the midst of soliciting proposals from agencies to perform these functions, Vermont learned that because it funds case management as a waiver service rather than as a Medicaid administrative activity, federal Medicaid waiver policy does not permit designation of one agency to provide case management to all participants within a geographic area. The state revised its plan to instead offer participants a choice of qualified case management providers while establishing Designated Administrative Agencies in each region to handle a range of local waiver program management functions, including coordination of the activities of the local interagency waiver teams.

Information and Assistance

In the absence of single entry points for service access, Vermont has placed a great deal of emphasis on making a wide range of program information easily available to older people and adults with disabilities. Although there are many doors for accessing services, two of the primary points for obtaining information about Vermont's long term care system are area agencies on aging and the Vermont Center for Independent Living. Older persons and their families usually call the Senior HelpLine, a toll-free statewide number that automatically routes them to an information and assistance coordinator at their local area agency on aging. In 2001 the state's five area agencies on aging received 22,027 requests for information and assistance through the Senior HelpLine, a 52-percent increase over five years earlier.

When the National Family Caregiver Support Program (NFCSP) was enacted in 2000, the state received new resources that among other things could be used to enhance its information and assistance services. With a focus on helping not only older people, but also their families, area agencies on aging used some of their NFCSP funds to expand information services to reach a new target population. Strategies adopted by the AAAs included redesigning their Web sites to make additional information available on-line, printing and disseminating more visually appealing brochures describing Vermont's long term care system, and writing regular newspaper columns on issues affecting older Vermonters. In addition, the Department of Aging and Disabilities conducted a statewide campaign in 2002 to promote greater awareness of the HelpLine, using television ads, radio and print media

The area agencies on aging also manage the State Health Insurance Counseling Program, which provides in-depth advice to older people about their health insurance choices and assists them in resolving problems with benefit programs.

The Vermont Center for Independent Living is the primary resource for information and assistance for adults with physical disabilities. Created in 1979 by a group of people with disabilities, the Center operates a statewide, toll-free information and assistance number. It also sponsors training and peer support programs that provide more intensive assistance on accessing community resources for people with disabilities and advocates for systemic changes that will benefit this population.

Assessment of Individual Needs

Designated Administrative Agencies are required to conduct outreach about HCBS waiver programs. They provide potential referral sources, such as physicians, hospital discharge planners, nursing home social workers, and local service providers, with program brochures and application forms that can connect people needing long term care with community services. The application package includes a pamphlet with hints about how to choose a case management agency. Once the individual has selected a case management agency and completed the application, it is sent to the relevant Designated Administrative Agency (DAA), which lets the case management agency know that an application has been received. If the applicant does not choose a case management agency, each region has agreed to a "default" case management agency. The participant can change case management agencies at any time.

For determination of Medicaid financial eligibility, the DAA forwards the application to the local Department of Prevention, Assistance, Transition and Health Access (PATH) office. Concurrently the DAA begins establishing an individual's program eligibility for waiver services. The case manager completes a priority assessment within seven working days of being notified about the application and informs the individual about the choice of nursing home care or services available under the waiver. The priority evaluation is an abbreviated assessment conducted in an individual's home or in a hospital or nursing home, depending on the applicant's current location.

The local Medicaid waiver team reviews initial evaluations and ranks them for priority enrollment into the state's waiver programs. Each team is made up principally of case managers from the home health agency and the area agency on aging; providers of adult day services, Enhanced Residential Care and nursing home services; representatives from PATH; and a hospital discharge planner.

As previously noted, a priority order has been established for waiver program admission, beginning with people in nursing homes and hospitals, followed by persons living in the community whose needs are reflected by high evaluation scores. Since waiver teams include case managers and service providers, interim services funded by other programs are usually arranged for those who are in a priority category but are on a wait list because either a slot is not available or others on the wait list are in a higher priority category. Depending on available resources, services can sometimes be arranged for persons who are not in one of the four priority categories.

The Department of Aging and Disabilities allocates waiver slots to each DAA monthly based in part upon regional variations in the number of people on program wait lists who are in the highest priority of need. Since the annual rate of participant turnover is approximately fifty percent, the state continually assesses where new slots should be allocated.

When a waiver slot becomes available within an area, a case manager from the agency chosen by the applicant at the top of the priority list visits the person to undertake a comprehensive needs assessment using the Independent Living Assessment (ILA). To facilitate a collaborative review of the assessment results by the local waiver team, the assessment is often a joint effort between the AAA and a registered nurse from the regional home health agency.

In addition to capturing information on a person's ability to conduct activities of daily living, the ILA includes domains on health status, mental health and cognition, demographic data, financial resources, home environment and informal supports. This same tool is used to assess participant needs in most of the other programs funded through the Department of Aging and Disabilities, including Attendant Services, Adult Day Services, Homemaker, Housing and Supportive Services, and the Older Americans Act.

Assessment results are entered into the state's comprehensive participant tracking system, the Service Accounting and Management System (SAMS). About one-half of the case managers have access to laptop computers, enabling them to concurrently enter information during the course of the assessment.

Providers of the state's single service programs, such as homemaker and adult day services, conduct their own assessments and in the case of state general revenue funded services, determine an individual's cost sharing obligation based upon a sliding fee scale. Information collected by these assessments is also entered into the SAMS database. The procedure for establishing eligibility for the Attendant Services Program will be discussed later in this report's section on self-directed supports, since the process itself is participant-directed and integral to the program's operational philosophy.

Long Term Care Options Education

Vermont has never established a formal pre-admission screening program that goes beyond simply establishing an individual's need for a nursing home level of care. To provide people seeking nursing home services with information about the entire range of available services and living arrangements, the Department of Aging and Disabilities created a new program called Options Education. Operated by home health agencies under contract with the state, the program provided education about all long term care options to persons living in their homes or a residential care home prior to entering a nursing home. People seeking nursing home services while in a hospital could be admitted without receiving Options Education, but it had to be offered within three days of nursing home admission. Options Education was not required to be offered to a new resident who was unlikely to stay for more than twenty days. If the individual stayed longer than 20 days, Options Education was offered at that point.

Eighteen months after it started, the state decided to terminate the program. It concluded that offering options education to people when they were already in a nursing home or are at the point of seeking nursing home admission was too late and as a result, the program had limited success in altering plans that individuals had already put in place. Instead, Vermont began a new program to offer people advice about support options at another common transition point—the hospital emergency room. It will operate as a pilot in two counties while the state evaluates whether it should be extended statewide.

Person-Centered Services

This series of case studies on state long term care initiatives focuses on two primary components of systemic reforms. The first, as described in the previous section of this report, is community access points, designed to provide identifiable places where people can get information, objective advice, and access to a wide range of community supports. The other essential component is a system of integrated services that places participants, not services or providers, at the center of funding and service planning.

Person-centered service systems, as presented in the following section of this report, have two key features. First, by integrating a wide range of support options, they enable people to make meaningful choices about their living arrangements, the types of supports they receive, and the manner in which services are provided. Second, by integrating systems management across multiple funding streams, the state's ability to achieve intended participant and program outcomes is enhanced.

Individual Service Plans

Using the results of the Independent Living Assessment as a starting point, the case manager and the individual entering the state's Home-Based Medicaid waiver program develop a service plan. One of the most basic decisions is the manner in which personal care services will be delivered. In 1997 the state introduced the option of participant-directed supports, and in the following year added surrogate-directed supports for situations where a participant may

have cognitive limitations. Currently over one-half of all waiver-financed personal care services are provided through these two options rather than through agencies.

During the service planning process, case managers specifically assess participants' interest and capacity to self-direct their services and, through the use of an "Ability To Direct Care Form," officially certify that participants or their surrogates can perform employer related functions. The Department of Aging and Disabilities contracts with a private non-profit organization to serve as the payroll agent for processing timesheets, paychecks and taxes; maintaining employment tax records for workers; and handling worker background checks. Participant or surrogate employers recruit, select and supervise their workers, develop work schedules, and authorize timesheets. To assist employers with these roles, the Department has developed a *Consumer and Surrogate Directed Services Employer Handbook* that spells out in detail the required procedures.

The service planning process for participants in the Enhanced Residential Care Waiver differs somewhat in that one of the primary considerations is matching a participant's needs with a residential care home's capabilities. Because residential care homes are licensed to provide services to persons who do not need a nursing home level of care, they must file for a variance from the Department of Aging and Disabilities' Division of Licensing and Protection on a case-by-case basis to admit a Medicaid waiver participant. In addition to the Independent Living Assessment conducted by the case manager, the provider completes the Residential Care Home Resident Assessment Tool to document the intensity of service needed by a participant. The Department uses these results to establish which of its three reimbursement rates will be paid for the care of a specific person.

When service planning is completed, the Designated Administrative Agency forwards a packet to the Department of Aging and Disabilities that includes the participant's assessment, service plan and materials specific to each waiver such as the Ability to Self Direct Form or the Residential Care Home Resident Assessment Tool. The Department formally reviews and approves all level of care determinations and all proposed service plans.

Self-Directed Supports

The Attendant Services Program exemplifies Vermont's commitment to participant-directed long term care. Designed to enable older people and adults with disabilities maintain their independence and take charge of their own supports, the program has four separate components—Medicaid (State Plan) Participant-Directed Attendant Care, General Fund Participant-Directed Attendant Care, Group-Directed Attendant Services and General Fund Personal Services. This program was the forerunner of all of the state's long term supports and provided the roadmap for extension of self-directed services into the Home-Based waiver program.

Under the Attendant Services Program, participants are the employer of record. They (or their agents if they have elected this option) hire, train, supervise, and schedule their personal care attendants. In addition, participants and attendants submit payroll reports biweekly to the fiscal intermediary that issues workers' checks and handles all withholdings and payroll

records. Two separate fiscal intermediaries support the Attendant Services program. For the General Fund Participant-Directed Attendant Care Program and the General Fund Personal Services Program, state government functions as the fiscal intermediary. When the state started covering self-directed services under the Medicaid state plan and the Home-Based waiver, it contracted with a private organization, Area Resources for Independent Services, to be the fiscal intermediary for participants in those programs.

People seeking attendant services and case managers who help them file applications contact the Department of Aging and Disabilities, whose staff conduct program eligibility assessments using the ILA, the same tool used by the state's other community programs. Participants have a hands-on role in managing the program through the eligibility and service authorization processes. A committee consisting of program participants reviews individual assessments to determine whether an applicant is eligible for Attendant Services. An employee of the Department of Aging and Disabilities (also a program participant) sits on the committee as well. Besides determining eligibility, the committee authorizes each participant's service hours. If funds are inadequate to meet all of a person's needs, the committee flags them for inclusion on an "unmet needs list," which gets addressed when funds become available through attrition or appropriation of additional state funds.

When participants leave the general revenue program, by law the Department of Aging and Disabilities must use at least 75 percent of the freed-up funds to target the unmet needs of existing participants. The remaining 25 percent can be used to accommodate people on the waiting list. According to state officials, the number of participants in the General Fund Attendant Services Program had, until recently, equaled the number of persons on the waiting list. The addition of a Medicaid state plan attendant service in 2001 has enabled more people to receive supports, but the waiting list remains sizable and the wait is up to two years.

The committee also determines the service eligibility of people who, due to income and proven ability to self-direct, qualify for the Medicaid state plan service and authorizes the number of hours to be provided. However, since the Medicaid service is an entitlement, eligible persons are not placed on a wait list and all needed hours are authorized. The committee annually reassesses both the eligibility and authorized service hours of all attendant program participants, regardless of their program funding source. Participants may request service plan changes, which are also reviewed by the eligibility committee.

Information and Quality Management Systems

Information Systems

One of the hallmarks of Vermont's long term care system is collaboration among multiple agencies in assessing participants' needs, providing case management, delivering services and handling local program administration. In such a system, being able to rely on an information system that uniformly collects information in an integrated manner across agencies and programs is particularly important. In Vermont the major vehicle for data collection and analysis is the Service Accounting and Management System (SAMS).

First developed in 1994, SAMS is a comprehensive database that includes assessment and eligibility information for participants in each of the state's community based service programs. As noted previously, about one-half of the state's case managers use laptop computers to collect assessment data and the state is working to extend this capability to all case managers. SAMS also contains data on all services received by individual program participants. Its report generating feature creates standardized reports that satisfy federal requirements for submission of data on the Older Americans Act as well as routine reports on service utilization within all of the Department's programs.

An additional database initially designed to support the management of the Medicaid waiver programs is linked to SAMS. Efforts are currently underway to integrate the two systems. The Department of Aging and Disabilities is also responsible for nursing home survey and certification and as a result, maintains the Minimum Data Set (MDS) which captures information about all nursing home residents. Using data from both SAMS and the MDS, the state can compare its nursing home populations with participants in home and community based service programs, a capability that was especially important in the early stages of implementing Act 160.

Quality Management System

Vermont's approach to quality management includes multiple aspects: frequent monitoring of participants' service plans, certification of individual case managers, provider licensing and certification, and surveys of program participants. In addition, the state's waiver programs have policies governing negotiated risk agreements, used when a participant's preferences are perceived to conflict with his or her health and safety.

Case Management: Vermont, like many states, views its case managers as the front line for ensuring that participants' needs are being met and has put in place several policies that underscore that role. In HCBS waiver programs, case managers contact each participant at least once a month, and conduct a face-to-face visit at least every 60 days. Reassessments are performed annually unless a change in a participant's situation triggers a need for a new assessment and/or service plan.

To achieve consistency in the manner in which case management is provided statewide, the Department of Aging and Disabilities recently established certification standards for individual case managers. To be certified, a case manager must pass a state-administered exam and participate annually in a minimum of twenty hours of professional development or training. In the process of establishing standards for individual case managers, Vermont re-examined its requirements for case management agencies, and as a result, added new provisions to emphasize participant outcomes the state expects agencies to achieve.

Licensing and Certification: The Division of Licensing and Protection in the Department of Aging and Disabilities conducts licensure surveys of the major providers of long term care services in Vermont—nursing homes, home health agencies, residential care homes, and assisted living residences. As part of its survey, the Division reviews the clinical condition and appropriateness of the initial and continued placement of waiver participants in specific

residential care homes. A variance review establishes whether the residential care home is capable of meeting the individual needs of a nursing home level of care resident while maintaining its ability to meet the needs of all other residents.

Participant Surveys: To measure participant satisfaction with its programs, the Department has contracted with an external organization for the past three years to conduct an annual statewide telephone and mail survey of a random sample of participants in its HCBS Medicaid waivers, Adult Day Services, Attendant Services, and Homemaker programs. People are queried about their satisfaction with the quality of services; the degree to which services meet their needs; scheduling and timeliness of services; their treatment by caregivers; and overall quality of life. Data on each measure is reported regionally and statewide, and while the findings were very positive, there was geographic variation. Results are widely disseminated and placed on the Department's web site, guiding quality improvement efforts at both the state and local levels.

Negotiated Risk Agreements: Vermont established a process for its Medicaid HCBS waiver programs to address situations where an individual's actions are perceived to conflict with health and welfare concerns. State officials note that this process was put in place to support a participant's self-determination to the maximum extent possible. When a participant is able to understand the consequences of his or her decisions and refuses to take actions or accept services that might ameliorate the risk of harm, the case manager initiates a risk agreement. It describes the participant's needs, including those that cannot be met; services that can be provided; and potential risks to the participant. In addition, the negotiated risk agreement documents that other support options (including nursing home services) have been explained to the participant, and that the participant understands and accepts the risks associated with the current service plan.

Lessons Learned

Over a period of six years Vermont dramatically increased the proportion of its long term care resources spent on home and community based services. In the process, it achieved remarkable consensus on policy goals among state officials, the disability community, aging advocates, service providers and program participants themselves. It was willing to experiment, to critique its approaches, and discard ones that were minimally successful. Vermont's experiences demonstrate that long term care reform is a journey that has both clear starting points, such as the passage of Act 160, and evolutionary paths, such as the varying forms of participant-directed services adopted over time. Several lessons can be drawn from its success.

Achieve a common vision among all stakeholders—After several failed attempts at long term care systems reform, Vermont created a state level coalition consisting of all relevant stakeholders to achieve consensus on policy goals and chart a path to reach them. Essential to this effort were the alliances developed among the aging and disability communities and state officials. Once the reform legislation designed by the coalition was enacted, similar coalitions were created throughout the state to foster a common understanding of how long term care programs should be designed in each local community.

Use simple, clear language to articulate policy goals—In Vermont there was no question about the desired end result. The phrase "shifting the balance" and the words "choice" and "options" were consistently used to frame new initiatives.

Set priorities for allocating scarce program resources—Vermont put in place a rigorous set of policies that governed who received services. The decision to give people residing in nursing homes top priority for admission to waiver programs was combined with a systematic effort to identify candidates for discharge and help them enroll in community programs. This strategy was instrumental in helping the state achieve its targeted level of savings from projected growth rates of nursing home expenditures.

Expand the types of available community options—In addition to increasing the supply of existing services, Vermont invested resources in supports that did not previously exist. In particular, it focused on enhancing options for people who needed both services and a supportive living environment. The Enhanced Residential Care Waiver and the Housing and Supportive Services Program are examples of investments made to meet the needs of a particular niche of people.

Strengthen all system components—To achieve a balanced long-term care system, the Department of Aging and Disabilities consistently tried to find ways to better support each segment of the system. For example: Medicaid funding of Day Health Services created a new source of revenue for adult day centers; rates were increased for individuals providing supports under the Attendant Services Program and the consumer and surrogate-directed options under the Waiver; funds were added to expand the number of persons served by the Attendant Services Program and HCBS Waivers; and case management rates were increased to help area agencies on aging and home health agencies recruit and retain qualified case managers. Each of these efforts helped support services and programs that are part of the web that makes up home and community based services.

Provide state leadership for change—The leadership of the Department of Aging and Disabilities set a tone for systems reform efforts that was inclusive, consultative and encouraging of experimentation, even if in the end, a particular approach might be less than successful. In addition, by placing a high value on communication with stakeholders and policy makers, the Department kept its agenda visible and clearly understood by all who had a role in helping achieve it.

Bibliography

Vermont Department of Aging and Disabilities:

"Act 160 Overview", 1998

"Annual Report: 2002"
"Annual Report: 2001"
"Annual Report: 2000"
"Annual Report: 1999"
"Legislative Oversight Report: Act 160", August 1998
"Long Term Care in Vermont: An Act 160 Update", February 20, 1998
"Legislative Oversight Report: Act 160", July 1997

"Attendant Services Program Regulations"

"Consumer and Surrogate Directed Services, Employer Handbook, revised, January 2003

"Home-Based Services Medicaid Waiver Policies and Procedures Manual"

"Enhanced Residential Care Medicaid Waiver Policies and Procedures Manual"

Home-Based Services and Enhanced Residential Care 1915(c) Waiver Applications

"Long Term Care in Vermont", 1991

"Nursing Home Medicaid Study", January 1998

"Shaping the Future of Long Term Care: 2000-2010", May 2003

"State Plan on Aging, 2002-2005"

Eiken, Steve; Hatzmann, Marjorie; Asciutto, Anthony; "One-to-One: Vermont's Nursing Home Transition Program", Medstat, June 4, 2003.

ORC Macro, "2001 Consumer Satisfaction Survey", May 31, 2002