

VERMONT 1115 DEMONSTRATION
THE VERMONT LONG-TERM CARE PLAN

Responses to December 2003 Questions from CMS

FUNDING QUESTIONS

1.

- A. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking the State to confirm to CMS that providers in the Vermont Long-Term Care Plan 1115 Demonstration (the Demonstration) would retain 100 percent of the payments. Would the State, through the Demonstration, participate in activities such as intergovernmental transfers or certified public expenditure payments, including the Federal and State share; or, would any portion of any payment be returned to the State, local governmental entity, or any other intermediary organization?

This confirms that the providers in the Vermont Long-Term Care Plan retain 100 percent of the provider payments and will not participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share. No portion of any payment will be returned to the State, local governmental entity, or any other intermediary organization.

Like other businesses, nursing facilities pay various taxes to the State, including sales taxes and property taxes. Vermont also imposes a per bed tax, which is a permissible tax pursuant to Section 1903(w) of the Social Security Act and is in compliance with 42 CFR 433.68. Vermont also maintains a permissible tax for home health providers.

- B. If the Demonstration would be required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Providers are not required to return any portion of payments. All routine recoupments (e.g. cost settlements, erroneous payments) due to the Vermont Medicaid program are shared with the federal government in accordance with Medicaid reporting requirements.

2.

- A. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State's share of the Medicaid payment for the Demonstration would be funded.

The State's share of all Medicaid payments under the Demonstration will be funded solely through appropriations from the legislature.

- B. Please describe whether the State's share would be from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share.

The State's share of payments under the Demonstration will be solely through appropriations from the legislature. No part of the State's share of Medicaid payment is funded by IGTs or CPEs. Vermont maintains a permissible nursing home bed tax. The proceeds of the tax are deposited in a health care trust fund from which funds are appropriated to the Medicaid program in addition to funds appropriated from the state general fund and other special funds (such as the health access trust fund which receives the proceeds from certain tobacco taxes).

- C. Please provide an estimate of total expenditures and State share amounts for the Medicaid payment. If any of the State share would be provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

The State's share of Demonstration expenditures shall be derived from the applicable FMAP rate at the time of payment (approximately 39.58% at the start of the Demonstration). No portion of the State share will be provided through CPEs or IGTs.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments would be made, please provide the total amount for each type of supplemental or enhanced payment made to the Demonstration.

Payments under the Demonstration will be made only for eligible services provided to individuals participating in the waiver program, as defined in the approved Protocol document. Payments will be based on existing fee schedules and rate methodologies; Vermont's rate methodologies are intended to reimburse providers for the reasonable costs of providing such services. While supplemental and enhanced nursing home payments are available under the State Plan, such payments are intended to recognize the additional, reasonable costs of particular services and address conditions within the Vermont labor market. Supplemental and enhanced payments are as follows:

- 1) Enhanced payments occasionally are made to reimburse very costly cases for residents with unique and specialized physical conditions (e.g., ventilator patients). The amount of the enhanced payment is determined on a case-by-case basis and is*

intended to cover the facilities' increased costs of providing care. The number of these individuals is very small (two to three cases per year). Vermont currently has three nursing facility residents in this category.

- 2) *Quality Incentive payments are available to nursing facilities. Each year, five quality incentive awards of \$25,000 each are made to Medicaid participating facilities based on certain published criteria related to state survey results and an efficiency element.*
- 3) *Wage supplement payments are made to privately owned nursing homes based on the amount of each facility's nursing wages in base year 1997 to defray the increases in wage costs incurred between the base year and the next rebase (which will must by law occur by January 1, 2005 at the latest. After the rebase, wage supplement payments will cease. (No wage supplement payments are made to state government owned and operated nursing facilities because they are paid retroactively based on reasonable costs.) The providers are required to make an annual accounting of the wage expenditures at their facility and at the time of the rebase there will be a reconciliation of the wage increases and amount of the wage supplement payments at each facility. If the wage supplement payment for any facility exceeds the amount of increased wage expenditures at the facility during the period, the state will recoup the difference and will treat such recoupments according to federal Medicaid accounting requirements.*

4. *This is applicable to inpatient hospital, outpatient hospital and clinic services. Please provide a detailed description of the methodology to be used by the state under the demonstration program to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).*

Note: Although not identified in the question, this response addresses the upper payment limit calculation for nursing facilities, also.

State-Owned or Operated Facilities

There are only two publicly-owned facilities in the State: the Vermont Veterans Home and the Vermont State Hospital.

The Vermont Veterans Home is the only nursing facility owned and operated by the State. The rates for this home are based on actual costs. The final rates for state owned facilities are set retroactively based on their settled cost report for the period which determines their actual reasonable allowable costs. Interim rates are based on a budget estimate of the reasonable allowable costs providing services. At the time the cost report is settled, if the amount actually paid under the interim rate exceeds the amount that should have been paid for the period using the final rate, the facility must return the excess payments to the state, which then accounts for the federal share according to federal reporting requirements. No other Medicaid payments are made. Therefore, payments will not exceed the upper payment limit.

The Vermont State Hospital is an inpatient psychiatric facility. No payments will be made to the Vermont State Hospital under the Long Term Care Demonstration.

Non-State Government Owned or Operated

Aside from the two facilities operated by the State and described above, there are no government-operated facilities in Vermont.

Privately Owned or Operated

As facility payments under the Long Term Care Demonstration are limited to nursing facilities, the rate methodology for nursing facilities is provided below.

As required by 42 C.F.R. § 447.272, the state makes reasonable estimates of the amounts that it would pay for services furnished by privately-owned and operated nursing facilities based on historic data from previous periods.

In Vermont, Medicaid rates for nursing homes are revised quarterly based on the average case-mix score for the Medicaid residents in the facility. The case-mix score used in the calculation is Vermont specific based on the status of the residents of the facility on the 15th of the month six months previous to the effective date of the rate. To calculate the upper limit, the resident's MDSs on which the Vermont Medicaid case-mix scores are based are "re-rugged" using the Medicare RUGs groupings. The state-wide annual average per diem Medicare rate that would have been paid for the Medicaid residents is then calculated by applying the Medicare PPS rate assigned for each case-mix category to the re-rugged Medicaid residents. This rate is the Medicaid upper payment limit.

Medicaid per diem payments then are calculated by for the same period by taking the Medicaid rate plus pharmacy costs for Medicaid residents in nursing facilities and Medicaid wage supplement payments for private nursing facilities (therapy costs are included in the Medicaid rate) less amounts paid by residents or other third party payers. The aggregate Medicaid payments then are compared to the upper limit. The State estimates that aggregate Medicaid payments to privately owned and operated nursing facilities will not exceed the Medicaid upper limit.

5. Would any public provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

A cost settlement occurs for the Vermont Veterans Home which ensures that Medicaid payments do not exceed the reasonable costs of providing services. If the amount actually paid under the interim rate exceeds the amount that should have been paid for

the period using the final rate, the facility must return the excess payments to the state which in turn accounts for the federal share of such recoupment.

LEVEL OF CARE

6. Please provide a comparison of the current “Nursing Home Level of Care Guidelines” (Appendix C) including the “Long-Term Care Eligibility Criteria – Highest Need Group” (Appendix B) with the proposed guidelines for nursing home level of care and HCBS eligibility. In addition, please provide the guidelines for differentiating the high and moderate need groups.

See attachments A, B, C, for the proposed criteria and Attachment D for current “Nursing Home Level of Care Guidelines”.

7.

A. Please describe your plans for developing criteria for assigning people into high versus moderate need groups (similar to Appendix B decision tree)?

Criteria for each group have been developed. See attachments A, B, and C for the clinical eligibility criteria for Highest, High and Moderate need groups.

B. Is there any plan to establish a decision support system for these and the highest need groups?

Yes. Each applicant will be subject to an established decision support system to ensure statewide consistency in clinical eligibility. The decision support system will consist of a uniform assessment and an eligibility screening tool.

C. Please describe how the State will assure consistency in assessment for these groups?

The State will implement comprehensive education, training and monitoring for DA&D regional staff as well as enhanced quality assurance and improvement procedures. State staff will review and approve requested changes in plans of care. DA&D Central Office utilization management staff and DA&D regional staff will conduct annual site visits, which will include a review of a representative sample of care plans. A random sample of 10% of the cases from each of the 13 Waiver Team areas (with a minimum of 5 cases per area) will be reviewed annually. (Note: Vermont has 13 local teams called Waiver Teams that meet on at least a monthly basis to discuss current cases, prioritize individuals on the waiting list for their area and work together to ensure that services for clients are well coordinated.)

DA&D will also continue the current practice of entering plans of care into the database and monitor plans of care by case manager and by type of agency. When warranted, utilization management staff will conduct more in depth investigations and mandate corrective action when necessary.

All case managers must be certified by the State and attend continuing education programs.

- D. Describe the process for how a moderate need individual would be identified, referred into the program and assessed.

Individuals will be identified and referred as they are today through multiple sources such as (but not limited to) hospitals, nursing homes, local Area Agencies on Aging, Home Health Agencies, adult day centers, health care providers and families. The State plans to develop application procedures that will assist in the identification of eligibility for this group. Case managers at the AAAs or Home Health Agencies will complete assessments. As is the case today, assessments will also be done by trained staff at the Adult Day Center, since they need the information for their care plan development. Those assessments will be available to local case managers and DA&D regional staff. All client data will reside on the Medicaid agency's databases.

- E. How much does a moderate need person need to change to become high need (or vice versa)?

Changes between groups will occur when the individual has an increase or decrease in functional ability, cognition or need for a change in the amount of care and services. See Attachments A, B, and C describing criteria for each group - Highest, High and Moderate Need.

BENEFITS

8. The proposal indicates that individuals previously eligible for long-term care services are not legally entitled to services under the demonstration unless they are in the highest need group. Although the demonstration will provide case management for all participants, additional benefits are dependent upon the availability of funding. As a consequence, benefits may fluctuate.

*As we stated in our proposal, we firmly believe that we will be able to serve everyone who is entitled to services in the Highest Need group **and** those individuals who qualify to enroll in the High Need group. We are already serving all the individuals who would currently fall into those two groups as we begin this new LTC program. Our assumption is that as turnover occurs and new people come to the program, we will see more individuals who qualify for the Highest Need group choosing care in settings other than a nursing home. If this assumption proves to be correct, we will have funds to pay for services for not only the High Need group (which we expect to be only 200-300 people), but also for individuals who qualify for the Moderate Need group.*

- A. How will the State ensure that individuals have adequate services as their needs increase?

For the Highest Need group, individuals who are eligible will be enrolled immediately. They will be assessed on an annual basis. If there is a significant change in the status of an

individual, the local case manager will update the Independent Living Assessment (ILA) and create a new care plan. DA&D regional staff must approve requested changes in plans of care.

For the High Need and Moderate Need groups, individuals who are eligible will be enrolled if funds are available. Once enrolled, individuals will have an annual reassessment and follow the same ILA review protocol as described above for the Highest Need group, including reviews at times other than annually for significant changes in status. If the individual's needs have changed enough to qualify him/her for a higher need group, that change would be made. Utilization Review of residents in nursing facilities includes quarterly review of case mix classification and subsequent grouping.

As long as individuals are enrolled and continue to need services they will not be disenrolled from the LTC program.

- B. How will the State work to prevent case managers and others from overstating needs to maintain access to services?

A regional employee of the Department of Aging and Disabilities (DA&D) will do the initial assessment and care plan. These individuals will be highly trained in performing assessments and will be very knowledgeable about all the available programs and services. If the consumer then decides to receive services at home, she/he will select a case management agency. The case manager will then complete a more in depth assessment and make any necessary changes to the plan of care. Each request for a change in the plan of care must be approved by the DA&D regional employee. Today DA&D central office staff perform those reviews. This methodology should create much tighter plans of care. Since the regional staff do the initial assessments and plans of care, they will be familiar with the individual and his/her situation when reviewing requested changes in the plan of care.

MANAGING SERVICES TO AVAILABLE FUNDING

9. As discussed above, the proposed demonstration builds flexibility into the program through establishing two groups whose service package will be managed within a funding cap. To control costs, the number of individuals entering the demonstration will be limited.

- A. At what point will individuals be added to the high and moderate needs groups?

We are considering the following methodology as a way to ensure that when funds are available, they are allocated to those areas of the state where there are waiting lists to be addressed.

- Divide the state into regions based on the areas covered by the current Waiver Teams*
- Retain 5% of the total budget for contingencies at the State level. Set up a process to allocate those funds near the end of the fiscal year if it appears they will not be needed to cover contingencies.*

- *At the start of the waiver, calculate monthly costs of all people currently in the nursing homes and on waivers in each part of the state.*
- *Use that amount as the starting point for each area.*
- *Quarterly review and reallocation of funds to those areas where there are waiting lists. Reports go to DAD regional staff and waiver teams.*
- *As individuals attrition off the program and new individuals sign up*
 1. *Regional DA&D staff inform the CO each time an individual is admitted to the Highest Need group and planned cost of care for that individual. For nursing facility placements, we will obtain the facility rate for each individual.*
 2. *DA&D staff keep waiting lists with estimates of POC/nursing home costs for each individual on the High Need group and eventually Moderate Need group as well.*
 3. *Develop a new methodology for prioritization for individuals on the High Need group. (Moderate Need eligibles will be enrolled on a “first come, first served” basis.)*
 4. *Waiver Teams (with regional DA&D staff facilitating) will prioritize individuals for High Need group.*
 5. *The list will be prioritized with equity between settings (i.e. home, nursing facility and Enhanced Residential Care - ERC). There will no bias as to cost of setting or whether the person currently resides in a particular setting.*

Our overall methodology for handling the initial assessment and creating the initial plan of care, coupled with periodic reviews of each individual’s need and DA&D regional staff reviews of requests for changes in plans of care will provide for efficient and effective management procedures. Utilization review in nursing facilities provides the opportunity to review the appropriateness of that setting. For those individuals for whom the setting is no longer desired or appropriate, discharge planning efforts would commence immediately.

Sample Monthly Report on Waiting Lists for High Need Group from DA&D Regional Staff

	Cost/Plan	Priority Score	Totals
# Home-Based clients			
# Nursing Home Clients			
# ERC Clients			
TOTAL			

B. How many individuals are currently on waiting lists for HCBS?

There were 64 people on the priority waiting list in December 2003; 18 waiting for an Enhanced Residential Care Waiver slot and 46 waiting for a Home-Based Waiver slot.

- C. What is the plan for transitioning individuals on the current HCBS waiting list to the demonstration?

Regional DA&D employees will assess each person using the new criteria. If an individual is found eligible for the Highest Need group, services will commence since this is the entitlement group. If the individual is eligible for the High Need group, she/he will receive 1115 Waiver services to the extent funds are available. We believe there will be adequate funding to fully serve this group.

- D. How will individuals' plans of care be managed, from assessment to assessment, as the availability of funds changes?

Any substantial change in an individual's situation calls for an updated assessment and usually a need for a change in the plan of care. Case managers will update the assessment and create new plans of care. The new plans will have to be approved by the regional DA&D employee. If an individual starts out in the High Need group and over time needs care at the Highest Need level, she/he will be entitled to move into that group and receive care in the most appropriate setting of choice. If she/he needs additional hours of care, but is still not at the Highest Need level, those hours will be added to the plan of care, subject to available funding. If, at any time, we have a waiting list for the High Need group and current enrollees need more hours, individuals on the waiting list will not be enrolled until sufficient funds are available to cover the cost of their plans of care. Funds permitting, we will allow these individuals to enroll in the Moderate Need group while they are waiting and thereby access case management, adult day and homemaker services.

- E. What infrastructure will need to be developed to support this management?

We believe we have nearly all the infrastructure in place to support the management of care plans and funding. We are working closely with our Medicaid Division (the Office of Vermont Health Access) and EDS to ensure that the necessary edit checks are in place and that we have access to data on a timely basis for our analysis.

Regional state employees will have PCs, laptops, printers and faxes. They will be connected to the state system through CITRIX and use a secure web system to transmit data to the central office. Our Public Guardians have operated out of their homes using this system for over 10 years and it works very well. They use the CITRIX system to enter their data directly into an SQL database that resides on a Central Office server. Regional staff will be able to perform assessments and upload the data to a secure server. In addition, they will be able to enter data on enrollees and the estimated cost of their plans of care. We are also working with the Agency of Human Services to determine the feasibility of using an encrypted e-mail system, which will further enhance our ability to

exchange data between the field and central office and among central office, field staff and case managers.

- F. Could individuals approved one year be denied services the next year if their service needs remain static or increase?

Once an individual is enrolled in any group, we intend to maintain services for that person as long as she/he remains eligible. We will set aside five (5%) of our funding to cover any unforeseen contingencies. These funds will allow us to continue to serve individuals already enrolled, even if we find that we experience periodic fluctuations in the enrollment for the Highest Need group.

- G. Please provide further explanation on how funds will be managed.

Please see the response in 9.A. above. In addition, we have access to EDS data through an application that allows us to work with this claims data on a real-time basis. Our five (5%) contingency fund will ensure that we can cover any end of the year adjustments.

BUDGET NEUTRALITY -

Overview of Vermont's Budget Neutrality Adjustments

At CMS' request, the budget neutrality tables have been reformatted, to better illustrate caseload and cost trends under the current system and the proposed waiver program. A number of adjustments have also been made, to address CMS concerns. Budget Neutrality will continue to be measured on an aggregate basis.

The revised tables are:

- *Rev 1 – Historical caseload*
- *Rev 2 – Historical per capita and aggregate expenditures*
- *Rev 3 - Projected caseload with and without the waiver*
- *Rev 4 – Projected per capita expenditures with and without the waiver*
- *Rev 5 – Projected aggregate expenditures with and without the waiver*

The revised tables include a number of updates and adjustments, as summarized below:

- *The historical tables have been updated to include utilization and expenditure data for state fiscal year 2003, which now serves as the base year. The five-year historical trends have been advanced one year, to the period SFY 1999 – 2003.*
- *Caseload and expenditure projections have been updated in accordance with the new five-year history.*

- “Applied Revenues”, which include patient share-of-cost amounts, have been added to the historical expenditure tables.
- The per capita costs for Nursing Facility residents under the waiver have been increased by 2 percent, versus the without waiver projection, to account for expected changes in case mix.
- The per capita costs for HCBS enrollees who previously would have resided in Nursing Facilities also has been increased by 2 percent relative to other HCBS enrollees, to account for the relatively higher expected case mix for this group.

10. The proposed budget neutrality approach included only long-term care services; however this intervention is likely to affect other Medicaid funded services. For example, nursing facility rates often include some payment for acute costs and prescription drugs. A budget neutrality formula that includes nursing facility costs, therefore, would include these costs.

- A. Please include all Medicaid-funded services, including State Plan services in budget neutrality calculations.

During the December 10 conference call with CMS, it was clarified that the Budget Neutrality table should present, for informational purposes, the cost of any acute care (State Plan) services furnished to HCBS and HCBS-ERC beneficiaries that are furnished to Nursing Facility residents through the per diem. The purpose of such an exercise would be to ensure that the relative difference in per capita costs between the three groups is based on the same set of services.

In contrast to some other states, Vermont does not include any prescription drug or other acute costs in its Nursing Facility per diem. (Over-the-counter drugs are covered under the per diem, but the per capita cost is nominal. The Nursing Facility Medical Director’s salary also is covered, but this is for performance of administrative duties and not direct patient care.) Vermont therefore believes that the tables fairly reflect the comparative costs of the three groups, without further adjustments.

- B. In addition, some participants will be paying co-payments and premiums and currently pay a patient share. Please include these funds in historical figures and projections during the demonstration.

The State has decided not to impose co-payments or premiums under the waiver program. Table Rev 2 includes line items for “Applied Revenues”, which primarily consists of patient share-of-cost under the current program.

- C. What are the assumptions behind the average cost per eligible for the highest, high, and moderate need group?

Per capita costs for the Highest Need group are based on historical expenditures for State Fiscal Year 2003, trended forward at the annual per capita inflation rate experienced during the period SFY 1999 – 2003. The per capita costs also include a case mix adjustment for some recipients, as noted in the overview.

Per capita costs for the High Need group have been established assuming HCBS recipients will make-up 90 percent of the caseload and Nursing Facility recipients the other 10 percent. It is further assumed that each segment's per capita cost will be 90 percent of the per capita cost for their respective counterparts in the Highest Need group. The final per capita amount is a weighted blend of the two segments.

Per capita costs for the Moderate Need group have been established assuming Adult Day Health recipients will make-up 25 percent of the caseload and Homemaker recipients the other 75 percent. It is further assumed that Adult Day recipients will receive an average of 796 hours of care per year (based on an analysis of the current population) at \$10.00 per hour, while Homemaker recipients will receive an average of 72 hours of care per year at \$17.00 per hour. All recipients will receive an average of eight hours of case management per year, at \$60.00 per hour. The final per capita amount is a weighted blend of the two segments.

It is important to note that the size of the Moderate Need group, and the services provided, will ultimately depend on the availability of funds. As more funding becomes available, the State will respond with some combination of higher enrollment and increased services.

- D. What is the fiscal impact on administrative expenditures as a result of increased outreach and assessment efforts?

The State provides approximately \$400,000 per year in grants to local Designated Administrative Agencies (DAA's) for outreach and assessment activities. In addition about \$200,000 has been dedicated to options education, public education and a utilization review contract for the HCBS Waiver. Although some of this money will be spent differently under the waiver, the State anticipates maintaining the same overall level of funding.

11.

- A. Please describe how the budget neutrality approach reflects the State's intention to "grandfather" current participants into the demonstration. For example, it appears that the number of member months for HCBS and ERC is the same under the demonstration and without the demonstration. If individuals are grandfathered into HCBS and ERC, will this number not be less over the course of the demonstration, as compared to without waiver figures, because of the impact of the new level of care and attrition?

Under the grandfathering provision, recipients who classified as High Need at the time of their next regular assessment will continue to receive the services they need, regardless

of whether or not they hold "entitlement" status. This population appears in the Budget Neutrality tables in the High Need line item starting in DY 1.

- B. In addition, the "with waiver" projections indicate the numbers of participants shifting from nursing facility to HCBS. How is this shift reflected in calculations?

The revised tables show this population as a discrete group. The group's per capita costs also have been separately calculated using the methodology described in the overview and below.

- C. The cost per eligible receiving nursing facility and HCBS under the demonstration is the same as the cost per eligible receiving nursing facility and HCBS under the current system. With changes to the level of care under the demonstration, the profile for this group will include fewer individuals with lighter needs thus increasing the average cost per eligible. Please explain why the "with waiver" cost per eligible is the same as the "without waiver" cost per eligible for these groups.

The costs are no longer identical. The per capita cost for the Nursing Facility population under the waiver has been increased by two percent, based on the results of an analysis performed on the existing Nursing Facility population. Specifically, the State re-calculated case mix weights and per diem rates after removing data for persons in the lowest four RUGS categories (approximately the same number of people as are projected to divert under the waiver). This produced a 1.5 percent increase in average Nursing Facility per diems. The 1.5 percent was raised to two percent to err on the side of conservatism. Equivalent data was not available for the HCBS population, so the two percent figure was used for this group as well.

12.

- A. The proposal includes projections indicating that nine percent of individuals eligible for nursing facility level of care services (1,032 over the course of the demonstration) would elect to obtain these services at home or in a community setting during the demonstration. Please describe your assumptions for arriving at this figure.

Our assumption is based on the outcomes of a survey done in Vermont the mid 1990's by AARP, in which over 95% of the individuals interviewed said they would prefer to receive their long-term care at home. We also looked at the growth of the waiver and decrease in nursing facility utilization since the inception of Act 160 in 1996. The obvious conclusion was that as we were able to add additional waiver slots, they provided the setting of choice and nursing facility utilization continued to decline.

The State also looked at the MDS data for individuals in the nursing home for a recent quarter and examined those data sets against the draft criteria for the Highest and High Need groups, thereby determining that there were individuals in certain RUGs categories and in the lowest case mix categories who could potentially be served in another setting, if they so chose.

- B. Of the individuals diverted from nursing facilities, what proportion is estimated to fall within the high need and moderate need groups?

The State believes that the great majority of these persons will remain in the Highest Need group and will be served under HCBS program. The Budget Neutrality tables assume that about 90 percent will be classified as Highest Need and served through HCBS, while 10 percent will be assessed as High Need. It is important to note that some High Need recipients will continue to be served in a Nursing Facility if that is their preference. None are expected to be classified as Moderate Need.

- C. How is this diversion reflected in the budget neutrality approach?

See above.

Table Rev 1

Vermont Long Term Care - Historical Caseload by Service Setting

Service Setting	State Fiscal Year					Percent Change	
	1999	2000	2001	2002	2003	Avg Annual	Five Years
Nursing Facility	2,349	2,287	2,156	2,057	2,101	-2.8%	-10.6%
HCBS	926	1,051	1,227	1,382	1,347	9.8%	45.5%
HCBS - ERC	<u>144</u>	<u>151</u>	<u>195</u>	<u>260</u>	<u>216</u>	<u>10.7%</u>	<u>50.0%</u>
Total Recipients	3,419	3,489	3,578	3,699	3,664	1.7%	7.2%

Table Rev 2

Vermont Long Term Care - Historical Per Capita and Aggregate Expenditures by Service Setting

Aggregate

Service Setting	State Fiscal Year					Percent Change	
	1999	2000	2001	2002	2003	Avg Annual	Five Years
Nursing Facility							
Medicaid Per Diems	\$ 71,127,371	\$ 73,327,187	\$ 73,688,601	\$ 78,251,498	\$ 80,599,043	3.0%	13.3%
Applied Revenues(1)	<u>19,468,173</u>	<u>20,279,347</u>	<u>20,358,585</u>	<u>21,865,473</u>	<u>22,740,092</u>	<u>4.0%</u>	<u>16.8%</u>
Sub-Total NF	\$ 90,595,545	\$ 93,606,534	\$ 94,047,186	\$ 100,116,971	\$ 103,339,135	3.4%	14.1%
HCBS							
Medicaid Payments	\$ 8,232,901	\$ 11,833,772	\$ 13,493,438	\$ 19,317,629	\$ 23,260,998	29.7%	182.5%
Applied Revenues(1)	<u>261,899</u>	<u>335,162</u>	<u>428,715</u>	<u>500,925</u>	<u>525,914</u>	<u>19.0%</u>	<u>100.8%</u>
Sub-Total HCBS	\$ 8,494,800	\$ 12,168,934	\$ 13,922,153	\$ 19,818,554	\$ 23,786,912	29.4%	180.0%
HCBS - ERC							
Medicaid Payments	\$ 771,737	\$ 1,025,352	\$ 1,219,894	\$ 1,770,393	\$ 2,156,820	29.3%	179.5%
Applied Revenues(1)	<u>7,565</u>	<u>11,573</u>	<u>39,941</u>	<u>80,806</u>	<u>97,534</u>	<u>89.5%</u>	<u>1189.3%</u>
Sub-Total HCBS-ERC	\$ 779,302	\$ 1,036,925	\$ 1,259,835	\$ 1,851,199	\$ 2,254,354	30.4%	189.3%
Total Expenditures	\$ 99,869,647	\$ 106,812,393	\$ 109,229,174	\$ 121,786,724	\$ 129,380,401	6.7%	29.5%

Annual Per Capita

Service Setting	State Fiscal Year					Percent Change	
	1999	2000	2001	2002	2003	Avg Annual	Five Years
Nursing Facility							
Medicaid Per Diems	\$ 30,280	\$ 32,063	\$ 34,178	\$ 38,048	\$ 38,367	6.1%	26.7%
Applied Revenues	<u>8,288</u>	<u>8,867</u>	<u>9,443</u>	<u>10,632</u>	<u>10,825</u>	<u>6.9%</u>	<u>30.6%</u>
Sub-Total NF	\$ 38,568	\$ 40,930	\$ 43,621	\$ 48,679	\$ 49,192	6.3%	27.5%
HCBS							
Medicaid Payments	\$ 8,891	\$ 11,260	\$ 10,997	\$ 13,978	\$ 17,269	18.1%	94.2%
Applied Revenues	<u>283</u>	<u>319</u>	<u>349</u>	<u>362</u>	<u>390</u>	<u>8.4%</u>	<u>38.0%</u>
Sub-Total HCBS	\$ 9,174	\$ 11,578	\$ 11,346	\$ 14,340	\$ 17,659	17.8%	92.5%
HCBS - ERC							
Medicaid Payments	\$ 5,359	\$ 6,790	\$ 6,256	\$ 6,809	\$ 9,985	16.8%	86.3%
Applied Revenues	<u>53</u>	<u>77</u>	<u>205</u>	<u>311</u>	<u>452</u>	<u>71.2%</u>	<u>759.5%</u>
Sub-Total HCBS-ERC	\$ 5,412	\$ 6,867	\$ 6,461	\$ 7,120	\$ 10,437	17.8%	92.9%
Average Per Capita Expend.	\$ 29,210	\$ 30,614	\$ 30,528	\$ 32,927	\$ 35,314	4.9%	20.9%

Note

1 Applied Revenue primarily consists of patient share-of-cost. NF figure for 2003 is an estimate based on AR percent of total in SFY 2002

Table Rev 4

Vermont Long Term Care - Annual Per Capita Expenditure by Service Setting - without and with Waiver

Without Waiver

Service Setting	Pre-Waiver Pd (Info Only)	
	2003 (actual)	2004 (est.)
Nursing Facility (per diem + SOC)	\$ 49,192	\$ 53,570
HCBS	17,659	20,847
HCBS - ERC	<u>10,437</u>	<u>12,193</u>
Average Per Capita Expenditures	\$ 35,314	\$ 38,388

State Fiscal Year					Percent Change	
2005	2006	2007	2008	2009	Avg Annual	Five Years
\$ 58,337	\$ 63,529	\$ 69,183	\$ 75,341	\$ 82,046	8.9%	40.6%
24,609	29,051	34,295	40,486	47,793	18.1%	94.2%
<u>14,245</u>	<u>16,643</u>	<u>19,444</u>	<u>22,716</u>	<u>26,540</u>	<u>16.8%</u>	<u>86.3%</u>
\$ 41,855	\$ 45,790	\$ 50,283	\$ 55,446	\$ 61,411	10.1%	46.7%

With Waiver

Service Setting	Pre-Waiver Pd (Info Only)	
	2003 (actual)	2004 (est.)
Highest Need		
Nursing Facility(1)	\$ 49,192	\$ 53,570
HCBS	17,659	20,847
HCBS growth due to waiver	-	-
HCBS-ERC	<u>10,437</u>	<u>12,193</u>
Sub-Total Highest Need	\$ 35,314	\$ 38,388
High Need(2)		
Nursing Facility	-	-
HCBS	-	-
Sub-Total High Need	-	-
Moderate Need (expansion) (3)	-	-
Average Per Capita Expenditures	\$ 35,314	\$ 38,388

State Fiscal Year					Percent Change	
2005	2006	2007	2008	2009	Avg Annual	Five Years
\$ 59,504	\$ 64,800	\$ 70,567	\$ 76,848	\$ 83,687	8.9%	40.6%
24,609	29,051	34,295	40,486	47,793	18.1%	94.2%
25,102	29,633	34,981	41,295	48,749	18.1%	94.2%
<u>14,245</u>	<u>16,643</u>	<u>19,444</u>	<u>22,716</u>	<u>26,540</u>	<u>16.8%</u>	<u>86.3%</u>
\$ 42,327	\$ 46,194	\$ 50,619	\$ 55,718	\$ 61,625	9.9%	45.6%
\$ 53,554	\$ 58,320	\$ 63,510	\$ 69,163	\$ 75,318	8.9%	40.6%
<u>22,149</u>	<u>26,146</u>	<u>30,866</u>	<u>36,437</u>	<u>43,014</u>	<u>18.1%</u>	<u>94.2%</u>
25,289	29,364	34,130	39,710	46,244	16.3%	82.9%
<u>3,350</u>	<u>3,954</u>	<u>4,668</u>	<u>5,511</u>	<u>6,505</u>	<u>18.1%</u>	<u>94.2%</u>
\$ 36,314	\$ 39,645	\$ 43,471	\$ 47,890	\$ 53,021	9.9%	46.0%

Notes:

- 1 Nursing Facility and HCBS ("growth due to waiver" line) per capita expenses increased 2% under waiver to reflect potential case mix change
- 2 High Needs group split 90%/10% between HCBS and NF. Per capita costs set equal to 90% of traditional HCBS and NF costs respectively
- 3 Moderate Needs group represents a pure expansion. Per capita costs based on projected Homemaker and Adult Day Health use rates among enrolled population

Table Rev 5

Vermont Long Term Care - Aggregate Expenditure by Service Setting - without and with Waiver

Without Waiver

Service Setting	Pre-Waiver Pd (Info Only)		State Fiscal Year					Five Years	Percent Change	
	2003 (actual)	2004 (est.)	2005	2006	2007	2008	2009		Avg Ann	Five Years
Nursing Facility (per diem + SOC)	\$ 103,339,135	\$ 113,661,681	\$ 125,015,346	\$ 137,503,129	\$ 151,238,317	\$ 166,345,512	\$ 182,961,766	\$ 763,064,071	10.0%	46.4%
HCBS	23,786,912	30,837,950	39,979,092	51,829,898	67,193,581	87,111,445	112,933,464	359,047,482	29.6%	182.5%
HCBS - ERC	<u>2,254,354</u>	<u>2,914,784</u>	<u>3,768,692</u>	<u>4,872,759</u>	<u>6,300,271</u>	<u>8,145,984</u>	<u>10,532,412</u>	<u>33,620,119</u>	<u>29.3%</u>	<u>179.5%</u>
Total Expenditures	\$ 129,380,401	\$ 147,414,415	\$ 168,763,131	\$ 194,205,787	\$ 224,732,170	\$ 261,602,942	\$ 306,427,642	\$ 1,155,731,671	16.1%	81.6%

With Waiver

Service Setting	Pre-Waiver Pd (Info Only)		State Fiscal Year					Five Years	Percent Change	
	2003 (actual)	2004 (est.)	2005	2006	2007	2008	2009		Avg Ann	Five Years
Highest Need										
Nursing Facility	\$ 103,339,135	\$ 113,661,681	\$ 117,314,401	\$ 128,331,671	\$ 140,379,406	\$ 153,553,542	\$ 167,958,901	\$ 707,537,921	9.4%	43.2%
HCBS	23,786,912	30,837,950	33,334,532	43,515,361	56,789,352	74,092,321	96,642,243	\$ 304,373,809	30.5%	189.9%
HCBS growth due to waiver	-	-	3,550,330	4,509,312	5,703,208	7,186,245	9,024,654	\$ 29,973,749	26.3%	154.2%
HCBS-ERC	<u>2,254,354</u>	<u>2,914,784</u>	<u>3,768,692</u>	<u>4,872,759</u>	<u>6,300,271</u>	<u>8,145,984</u>	<u>10,532,412</u>	<u>\$ 33,620,119</u>	<u>29.3%</u>	<u>179.5%</u>
Sub-Total Highest Need	\$ 129,380,401	\$ 147,414,415	\$ 157,967,956	\$ 181,229,103	\$ 209,172,236	\$ 242,978,092	\$ 284,158,210	\$ 1,075,505,598	15.8%	79.9%
High Need										
Nursing Facility	-	-	\$ 1,606,609	\$ 1,854,573	\$ 2,140,808	\$ 2,471,220	\$ 2,852,628	\$ 10,925,837	15.4%	77.6%
HCBS	-	-	<u>5,980,104</u>	<u>7,483,083</u>	<u>9,363,807</u>	<u>11,717,212</u>	<u>14,662,099</u>	<u>\$ 49,206,305</u>	<u>25.1%</u>	<u>145.2%</u>
Sub-Total High Need	-	-	7,586,713	9,337,656	11,504,614	14,188,432	17,514,727	\$ 60,132,142	23.3%	130.9%
Moderate Need (expansion)	-	-	<u>837,438</u>	<u>1,087,454</u>	<u>1,412,114</u>	<u>1,833,701</u>	<u>2,381,152</u>	<u>\$ 7,551,859</u>	<u>29.9%</u>	<u>184.3%</u>
Total Expenditures	\$ 129,380,401	\$ 147,414,415	\$ 166,392,106	\$ 191,654,214	\$ 222,088,965	\$ 259,000,225	\$ 304,054,089	\$ 1,143,189,598	16.3%	82.7%

Net savings under waiver due to changes in service settings: \$ 3,208,462 \$ 3,639,028 \$ 4,055,319 \$ 4,436,417 \$ 4,754,705 \$ 20,093,931
Cost of Moderate Needs group (expansion population): (837,438) (1,087,454) (1,412,114) (1,833,701) (2,381,152) (7,551,859)
Net Surplus (Deficit): \$ 2,371,025 \$ 2,551,574 \$ 2,643,205 \$ 2,602,717 \$ 2,373,553 \$ 12,542,073

TRANSITION BETWEEN CATEGORIES IN THE DEMONSTRATION

13.

- A. Please describe the process and periodicity for assessing (and addressing) individuals' changing needs.

Each person applying for services will receive a preliminary assessment to determine which clinical eligibility criteria she/he meets. If the individual chooses to reside in a nursing facility, MDS assessments will be performed on the same schedule as today. If the individual chooses home- and community-based care, the case manager then performs a comprehensive assessment and recommends any necessary changes to the preliminary plan of care. The Vermont Independent Living Assessment (ILA) will be used for all individuals who choose home-and community-based services. (Vermont will explore using one assessment tool for ERC residents. Currently both the ILA and the Residential Care Home – Assisted Living Residence Resident Assessment Tool (RCHRAT) are used for this population). Updates to assessments are performed at least annually and whenever a significant change occurs in the individual's situation. Regional DA&D staff must approve each requested change in a plan of care. These individuals will explain the role of the case manager to the consumer and ask the individual to choose whether she/he would like to receive case management services from the local Area Agency on Agency or the home health agency. These are the case management agencies that exist today under our two 1915(c) waivers.

- B. Describe the case management and assessment process (including the assessment tools) for the proposed three-tier system (if not addressed above).

Vermont is considering using the just the Intake section of the ILA for the Moderate Need group, unless the individual attends an Adult Day Center, and then the entire ILA is necessary for case planning purposes at the Center. The Intake section contains questions that collect demographic information plus data on ADL/IADL needs, living situation, cognition, health issues, nutrition and participation in current services and benefit programs. MDS assessments will be used as they are today in nursing facilities.

Please describe how managers will be informed when there has been a significant change in an individual's status and reassessment is therefore required.

Local case managers will be required to have monthly face-to-face visits with their clients in the Highest Need and High Need groups. At that time they will check for any changes in status. In addition, the client and/or care providers know how to contact the case manager and report any significant changes. Reassessment always occurs if the individual has been hospitalized or has spent time in a nursing home (other than respite time).

Individuals in the Moderate Need group will also receive annual reassessments and reassessments whenever they experience a significant change in status. Case managers will be in touch with these individuals by phone and face-to-face visits (frequency of check-ins is yet to be determined) and will also rely on reports from the adult day

centers, Homemaker staff and other care providers to report any significant changes in status.

SERVICES FOR INDIVIDUALS WITH LONG-TERM DISABILITIES

14.

- A. Please describe the State's services for individuals with long-term disabilities including State-funded and Federally-funded programs.

The Vermont Agency of Human Services (Agency) is the "single state agency" for federal Medicaid purposes. It serves as an umbrella agency for six departments. Three departments are heavily involved with the administration of various aspects of Medicaid Long Term Care(LTC): the Department of Aging and Disabilities (DA&D); the Department of Developmental and Mental Health Services (DDMHS); and the Department of Prevention, Assistance, Transition and Health Access (PATH).

Historically, DA&D and DDMHS have overseen the operation of five 1915(c) waivers. They ensure the delivery of Medicaid LTC services within their allocated budgets. The overall administration of the Medicaid program is conducted by the Medicaid Director who works within a division of the Department of PATH in the Office of Vermont Health Access (OVHA). The Medicaid Director, together with four other PATH departments and its Commissioner's Office, establish and oversee the global Medicaid budget, which includes the 1915(c) waivers.

The proposed 1115 LTC waiver will remain a component of the larger Vermont Medicaid Program. DA&D will, as now, manage the day-to-day operations of LTC services delivery. Within DA&D are the Division of Advocacy and Independent Living, the Division of Licensing and Protection, the Division of Vocational Rehabilitation, the Division of the Blind and Visually Impaired, the Vermont Assistive Technology Project and Vermont's ADA Coordinator.

PATH will remain responsible for overseeing the billing and reporting (Division of Administrative Services), electronic infrastructure (Division of Computer Services), regulation (Division of Regulation, Planning and Policy), financial and general Medicaid eligibility determinations (Family Services Division), as well as Medicaid provider reimbursement and enrollment (OVHA).

The LTC 1115 budget will be overseen by PATH's Administrative Services Division and managed by the Medicaid Director, OVHA's LTC Director, and the DA&D Commissioner. Responsibility for Quality Control will be shared between DA&D's clinical staff and PATH's Administrative Division's QC staff.

Vermont is a national leader in community integration for its citizens with disabilities and is one of the least institutionalized states in the Northeast.

Mental Health Services

The Division of Mental Health's (DMH) Adult Unit contracts with ten private, nonprofit community mental health centers (Designated Agencies) to provide Community Rehabilitation and Treatment (CRT) services to approximately 3,000 adults with severe mental illness. The CRT program offers a wide array of services, including service planning and coordination; community supports; employment services; clinical interventions; consultation, education, and advocacy; housing/home supports; and transportation.

For clients whose needs exceed community-based resources, inpatient services are provided through the Vermont State Hospital or designated community hospitals. Eighty-six percent (86%) of support for CRT services comes from Medicaid, (state General Funds and matching federal funds). The remaining 14 percent comes from other federal, state, and local sources.

In the past year, the average daily census of the Vermont State Hospital was between forty and fifty. Over two-thirds of Vermont's mental-health budget now goes into voluntary community programs.

Under a major restructuring that began in 1995, there have been two important changes in the financing of mental-health services. Amendments to Vermont's current 1115 waiver provide behavioral-health coverage to 22,000 uninsured Vermonters and allow the introduction of case rate payments to Designated Agencies for CRT services for adults with severe mental illness and long-term needs. The case rate system offers the potential of complete flexibility in the kinds of services that can be provided or purchased. One of the main goals of restructuring has been to increase the role of consumers and families in governance of the Designated Agencies and state and local standing committees.

For the past 6 years, the Vermont Recovery Education Project has empowered adults with psychiatric disabilities by helping them work toward goals of their choice. It is administered by Vermont Psychiatric Survivors, Inc. (VPS), a statewide, non-profit survivor-run organization. The Recovery Workgroup, composed of consumers, family members and providers, serves as an advisory board to the Project.

Through 40-hour Recovery Education Cycles, consumers, family members, supporters and providers are taught key recovery concepts such as self-advocacy; hope; personal responsibility; medical care and health management; developing support systems; suicide prevention, and preparation of a Wellness Recovery Action Plan (WRAP). The WRAP is a personal monitoring system for documenting strategies for managing, preventing and reducing symptoms. Individuals learn self-management of mental illness and develop their own support systems, increasing connections with the community and thereby reducing the need for psychiatric treatment such as hospitalization. Consumers and professionals who have been trained as Recovery Educators provide Recovery Education services.

DMH also funds Another Way, a drop-in center in Montpelier operated by the consumers and ex-patients of the Green Mountain Support Group. The center offers peer counseling, advocacy, social support, and assistance in obtaining public benefits and housing. Grants to the National Alliance for the Mentally Ill of Vermont (NAMI—VT) support activities for families dealing with severe mental illness.

Developmental Disabilities

Since the closing of Brandon Training School in 1993, Vermont has had no large residential settings for people with developmental disabilities. About 40% of people with developmental disabilities who receive services or support live independently or with their families. Ninety-eight percent (98%) of people receiving residential services live in settings with 1 or 2 individuals; the remaining 2% live in settings with six or fewer individuals.

DDS regulations implementing Vermont's Developmental Disabilities Act explicitly include self-determination principles. The DDS guidelines for development of individual support agreements are person-centered and designed to elicit the needs and wishes of the individual. About 550 people with developmental disabilities, directly or through surrogates, self-manage their services, including hiring, training and supervising direct care staff. State law requires Designated Agencies to maintain boards of directors composed of a majority of individuals with disabilities and their family members. Local provider and state advisory committees, with the same majority membership, oversee program and policy development, quality assurance and grievance procedures.

In 1997, DDS received a three-year grant from the Robert Wood Johnson Foundation to establish the Vermont Self-Determination Project. State funds supported this project through 2002. This initiative employs teams of self-advocates, family members and provider representatives as trainers to increase consumer choice and control. DDS also supports Green Mountain Self-Advocates, a self-advocate directed organization with a statewide network of 17 peer support groups. Green Mountain Self-Advocates provides support, including peer support, to assist people with developmental disabilities speak for themselves, make their own choices, serve on local and statewide boards, and advocate for systems change.

Under a contract with the Agency of Human Services, the Center on Disability and Community Inclusion at the University of Vermont is developing a statewide pool of trained, independent service brokers (ISB's) to assist consumers who wish to self-manage their services. The services of the ISB's will be available across age and disability groups.

Real Choice Systems Change Grant

In October 2001, Vermont was awarded a \$2 million Real Choice Systems Change Grant from the Centers for Medicaid and Medicare Services to promote continued progress toward community integration of services for frail elders and consumers with chronic

conditions. The grant initiatives are designed to address issues identified as barriers to adults with disabilities (both physical and mental disabilities) with respect to where, how and by whom those services are delivered. The Real Choice Systems Change Grant is a fully collaborative project among DA&D and the Divisions of Developmental Services and Mental Health Services, as well as several disability organizations, including the Vermont Center for Independent Living (VCIL), Vermont Psychiatric Survivors, Inc., Green Mountain Self-Advocates, and ARC-VT. Real Choice activities include:

- creation of an accessible cross-age and disability system to provide quality information and assistance;
- provision of self-advocacy skills to consumers and families, and training for providers to promote facilitation of consumer self-advocacy;
- development of an expanded 1115 Medicaid Waiver to create access to home and community-based care for elders and younger adults with physical disabilities that is equal to nursing home access;
- creation of models that will improve direct care staffing such as an association for direct care workers; and
- creation of a pilot project for direct consumer funding of developmental services, carrying on the work started under the Robert Wood Johnson Foundation grant.

Long-Term Care Services for Elders and Younger Adults with Disabilities

Long-term care services for elders and younger adults with physical disabilities outside the nursing facility setting are provided through a variety of programs. Vermont's Home and Community Based (HCB) Waivers provided an average of 30 hours per week of personal care assistance to 1,347 individuals in SFY '03. In addition, care plans also included case management, and if appropriate and desired, adult day services, respite, assistive devices, and home modification.

The Enhanced Residential Care (ERC) Medicaid Waiver Program provides 24-hour care (personal care, medication management, nursing assessment, recreational activities, supervision, and case management services) to 216 individuals in 48 licensed residential care homes during SFY '03. Vermont has created a model living environment for nine severely disabled younger adults with disabilities who now live in a group setting in individual apartments and share their caregivers. Vermont recently promulgated licensing regulations for assisted living residences.

Our first licensed affordable assisted living residence opened in July 2003 with 28 private, fully accessible apartments and a residential care home recently converted to assisted living with a dementia care unit. Nine projects are in the planning and design stages. The Department of Aging and Disabilities also supports two home sharing programs, where homeowners and care providers are matched to achieve a mutually beneficial living situation. A home modification program is run by the Vermont Center for Independent Living with funds from several different sources including the Vermont Housing Conservation Board and DA&D. This program helps to pay for ramps,

widening of door ways and bathroom modifications that allow consumers to maintain their independence. The Assistive Community Care Services program (a Medicaid State Plan service) helped approximately 625 individuals receive services in licensed Level III residential care homes.

State-funded Attendant Services Programs (Personal Assistance, Participant-Directed Attendant Care –both State-funded and Medicaid-funded- and Group-Directed Attendant Care) allow over 300 elders and younger adults with physical disabilities to hire, train and supervise their caregivers directly or through a surrogate.

Adult Day Services, available at 17 sites, provide supervision, therapeutic activities, personal care, nursing services, social work, nutrition, occupational, and physical and speech therapy service to 800 people. Older American's Act nutrition programs provide home-delivered meals annually to 13,000 seniors. General Funds provide home-delivered meals to 441 younger adults with physical disabilities. The Homemaker Program provides help with housekeeping to 850 elders and people with disabilities.

New initiatives designed to meet needs that might otherwise lead to nursing facility admission include supportive services in congregate housing; dementia respite services; a mental health and aging initiative that provides in-home assessment and counseling for elders and locally administered flexible funds to pay for services not covered by other programs.

Local Medicaid Waiver teams ensure that waiver applicants are assessed and that applicants who are in greatest need access waiver services first. The five Area Agencies on Aging provide information and assistance to elders and their family members as well as case management and oversight of the nutrition programs. They also administer the National Family Caregivers Support Program and four out of five help administer the Dementia Respite grant program.

For younger adults with physical disabilities, information and assistance, peer support and home-delivered meals are provided by the Vermont Center for Independent Living (VCIL). Twelve Medicare-certified home health agencies (HHA's) provide home care services, including homemaker services, personal care and respite services under the current DA&D 1915(c) waivers.

Consumers identify their own needs as part of their assessment for waiver eligibility and participate in the development of their plan of care. Over 50% of the personal care services delivered under the Waiver are through use of the HCB Waiver consumer or surrogate-directed options. During the most recent quarter, 418 consumers chose this option and received an average of 32 hours a week of personal care. Vermont's Attendant Services Program also allows consumers to hire, train and supervise their own attendants. A committee of consumers determines eligibility in this attendant care program.

- B. *Please describe how these programs and services interface with the program described in this demonstration?*

Vermont recognizes that it is important to effectively and efficiently utilize all available resources to help individuals remain as independent as possible, for as long as possible. The two of the three existing DA&D 1915(c) waivers (ERC and Home-Based Waivers) will be rolled into the 1115 Waiver; the TBI Waiver will remain a 1915(c) waiver, discreet from the 1115 Waiver. Individuals in the Highest Need and High Need groups will access services from the following menu of options: personal care, adult day services, respite, case management, companion services, assistive devices, home modification, nursing facility or Enhanced Residential Home care. These individuals are also eligible for Medicaid State Plan services.

Individuals in the Moderate Need group will be able to access Adult Day, Homemaker and case management services. Those who meet the separate eligibility test for "Community Medicaid" will be able to access Medicaid services. We are still trying to determine how this LTC Waiver will interface with Community Medicaid. Access to the Moderate Need group will be dependent on the availability of funds. The list of services will be expanded as funds become available.

Services are well coordinated for these individuals, since the home- and community-based organizations provide both 1915(c) Waiver and non-Waiver services. These organizations are all represented on the local Waiver Teams who discuss how services can be coordinated and delivered for both Waiver and non-Waiver clients.

ADDITIONAL QUESTIONS

15. The moderate need group is identified as "individuals who do not meet current nursing facility or Home and Community Based Services waiver eligibility criteria, but are believed to be at risk of institutional placement based on the assessed care needs" over the next 18 to 24 months. Regarding the moderate need group:

- A. The charts at the end of the application imply that the average user will receive 1.88 hours of case management per year. How will this amount of case management alter the progression of disability?

Based on an analysis of the amount of AAA case management time provided to current Homemaker and Adult Day Center clients (non-Waiver clients) in SFY'03, we now estimate that these individuals would receive an average of 8 hours of case management per year. Case managers will be able to assess clients, work with them to set up a care plan that would include informal supports, 1115 Waiver services and other non-waiver services. Case managers would also work closely with the consumer's health care providers and monitor any changes in status through regular contacts with consumers. We have not yet determined the frequency of face-to-face visits with clients.

Reassessments would occur annually, or when there is a significant change in the individual's status.

- B. What are the assumptions about labor use for accomplishing these activities for the moderate level group and for the high and highest need groups?

We have worked closely with our 12 Home Health Agencies as we developed our assumptions and projections for this long-term care program. Knowing that change will be gradual, the agencies have told us that they will be able to meet the demand for personal care services for the Highest and High Need groups. Over half of the Homemaker clients and 75% of the adult day clients already receive case management from the AAAs. These organizations have told us that they will be able to hire more case managers if the 1115 Waiver is approved. As people are given choices for where they can receive their services, we anticipate that more people will choose home and community based services and therefore the staffing needs for nursing facilities will remain the same or decrease slightly. We have also seen a steady increase in the use of our Consumer and Surrogate Directed options under the Home-Based Waiver and anticipate that many consumers will continue to want to recruit their own caregivers.

Vermont also has several initiatives underway to improve caregiver recruitment and retention, e.g. the Better Jobs-Better Care grant from the Robert Wood Johnson administration, the Professional Caregiver Association supported with start up funds from the Real Choice Systems Change Grant and our "Gold Star Employer" award program for nursing home and home health agencies who institute measurable best practices in the field of employee recruitment and retention.

- C. The application states that the project is intended to test the hypothesis that early intervention will prevent inappropriate institutionalization. Describe the population that would make up the moderate need group—number and distribution, characteristics, level of function, current service use.

The eligibility criteria (see Attachment C) will help describe the population we anticipate enrolling as the Moderate Need group. The criteria depict our current Homemaker and Adult Day (non-Waiver) population. Data describing details about this group were taken from the short version (Intake Section) of the Independent Living Assessment (ILA). (See Attachment E.) We anticipate being able to ultimately enroll and serve approximately 1,050 individuals this group, although the actual number of consumers served will depend on the funds available. We will not spend more money than we have.

- D. Please specify the assumptions regarding the impact of case management on future use of services?

For the Highest Need and High Need group, we anticipate that our proposed protocol (having State staff do the initial assessment and plan of care) will result in plans of care that are built more closely on an individual's strengths and needs, and that a greater

consistency of assessment and plan development will be achieved across the state. Since the menu of services available to individuals in the Highest and High Need groups is the same as that available to 1915(c) Waiver clients today (including case management services), we do not anticipate that case management will have an impact on the future use of those services, other than a potential for a slight increase in the amount of personal care services provided if our acuity numbers increase for home and community-based clients. Since we already prioritize admission to our two 1915(c) Waivers, admitting only those who exhibit the greatest need, we do not anticipate much of a change in the level of personal care service.

Case management for the Moderate Need group (for those individuals who are not currently receiving case management from the AAA), could increase utilization of some benefit programs such as food stamps, fuel assistance, housing, transportation and pharmacy benefit programs. Access to these types of programs, along with Homemaker services and Adult Day services would be important in meeting the goal of maintaining or slowing the rate of decline in an individual's health and ability to function in his/her community. Because enrollment in this group will be tied directly to the amount of funding available, we do not anticipate any unmanageable stresses on these programs.

- E. If the moderate needs group is not served, they are likely to move into the higher needs groups. Is there an overlap between individuals in the moderate needs group and those receiving a prescription drug benefit in conjunction with the Vermont Health Access Plan (VHAP)?

If individuals in the moderate needs group are not served under the 1115 long term care waiver, they may be separately eligible for Medicaid services through community Medicaid or one of Vermont's pharmacy programs.

- F. The prescription drug benefit plus disease management may be preventing spend-down. What opportunities does the State have via this demonstration in conjunction with other efforts/programs currently underway to provide cost-effective and clinically appropriate care to individuals eligible for Medicare and Medicaid?

Vermont has just announced plans for a Chronic Care Initiative, which could provide opportunities in the future to partner with the work of that initiative to help improve the health outcomes of Vermonters enrolled in the 1115 Waiver. We have achieved successes in our Vermont Independence Project (VIP), which ended 12/31/03. VIP was designed to test the efficacy of co-locating case managers from the Area Agencies on Aging in primary care physician offices. DA&D and the AAAs are already involved in many Successful Aging and Independent Living (SAIL) initiatives, some of which might appropriately be funded by the 1115 Waiver in the future. Another opportunity to both save funds and improve the health outcomes of individuals would be to expand our ability to offer medication management as a service. Vermont also has a grant from CDC to develop a Disability and Health Promotion Program. The results of this work will also

help guide new initiatives that could achieve better health outcomes for the 1115 Waiver enrollees.

- G. The State proposes to roll individuals eligible under the Vermont Independent Project (VIP) into the demonstration if approved. Please provide more details regarding the VIP's objectives and the program's inter-relationship with the proposed demonstration.

In April 2003, Vermont responded to a Request for Information from the Centers for Medicare and Medicaid Service regarding fee-for-service dual eligible demonstration options. Vermont's proposal entitled "Managing Chronic Conditions in the Primary Care Setting: A Medicare/Medicaid Managed Fee-For Service Proposal" outlined an expansion of the Vermont Independence Project's Care Partner program with case managers physically co-located at physician offices assisting with chronic illness care management for dual eligibles. The 1115 long term care demonstration is not relying upon approval of a solicitation for proposals nor an approved Dual eligible fee-for-service demonstration from Vermont.

- H. What is the impact on the demonstration if the Medicare Vermont Independence Project is not approved? –

- I. *If the Vermont Independence Project fee-for service dual eligible demonstration is not approved the 1115 long term care waiver demonstration will still increase the amount, duration and scope of case management services for dually eligible Vermonters. However, the Medicare demonstration would allow funding for chronic care case management at physician offices.*

16. The proposal indicates Vermont would like to develop a Cash and Counseling pilot program (now known as Independence Plus).

- A. What are your plans for addressing the Independence Plus Essential Elements (EE)?
- B. Please include a time line for bring the essential elements on line.
- C. Include descriptions of the proposed process for Person Centered Planning and Individual Budgets.
- D. Also discuss plans for Self Directed Supports (Financial Management Services, Counseling and Self-Directed Brokers) and Quality Assurance, including Participant Protections.

Responses to 16 A-D

The state has just begun to plan for the development of the Cash and Counseling pilot. (Note – we have already received feedback from consumers that the title of this project should be changed and will definitely consider that input.) Vermont thinks that it is important to have consumers involved in the planning process, so a series of meeting involving consumers and providers have been planned to develop policy for the Cash and Counseling Program. Development of this policy will answer the questions in 16 A – D.

The first meeting was a telephone conference call held on December 19, 2003. This conference call introduced interested parties to the concept of Cash and Counseling. This included:

- Definition of Cash & Counseling*
- Goals*
- Major Components (Comparison of New Jersey and Arkansas policy)*
 - Eligibility & Appropriateness*
 - Outreach & Enrollment*
 - Planning the Use of the Cash Benefit*
 - Determining the Level of the Cash Allowance*
 - Consulting and Fiscal Services*

Additional meetings are planned over Vermont Interactive Television to allow for maximum participation. The schedule is as follows:

1st meeting January 13th

- Develop definition and goals for Vermont*
- Develop policy recommendation for Eligibility & Appropriateness*

2nd meeting January 27

- Develop policy recommendation for:*
 - Outreach and Enrollment*
 - Planning the Use of the Cash Benefit*
 - Determining the Level of the Cash Allowance*

3rd meeting February 10th

- Develop policy recommendations for:*
 - Consulting and Fiscal Services*
 - Review and finalize all policy recommendations*

- E. Discuss any changes that would be made to existing screening, assessment or needs development tools and enhancement such as automation or web-based developments for tools, budgeting and monitoring.

The State does not plan to change the Independent Living Assessment (ILA) tool, which was updated last year; however, we will review the screening tool we use to determine whether an individual is able to direct his/her own care (See Attachment F). Vermont will explore using one assessment tool for ERC residents. Currently both the ILA and the Residential Care Home – Assisted Living Residence Resident Assessment Tool (RCHRAT) are used for this population). The need for development of web-based tools for budgeting and monitoring would be identified during the planning process. These issues will be addressed when policy is developed for consulting and fiscal services.

17.

- A. What are the health characteristics of the individuals to be included in the demonstration?

Please see the scenarios below for examples of individuals who would be enrolled in the Highest and High Need groups. Attachments C and D give more information about the potential Moderate Need enrollees.

- B. Please describe the disabling conditions of the population currently receiving payment of long-term care services through Medicaid and for the demonstration's expansion groups.

Please see Attachments A-D to understand the criteria for the three groups.

- C. In addition, please describe how the definition of physical disability is applied in this demonstration. It is unclear if physical disability includes blindness, deafness and co-morbidity (i.e., where primary disability is physical and secondary includes other cognitive/mental and/or substance abuse disorders).

Physical disability as applied to this demonstration and to DA&D's current 1915(c) Home- and Community-Based Waivers includes those persons whose primary need is for personal care services because of their physical disability. In accordance with Federal law, although blindness by itself may meet the clinical eligibility criteria for SSI-related Medicaid services, it would not necessarily result in a need for long term care services. Deafness will qualify individuals for the waiver if clinical criteria, besides the fact of the diagnosis, are met. Specifically, we have designed the Independent Living Assessment to determine the level of personal care assistance needed. The ILA determines whether the individual can: (1) perform the activity independently; (2) perform the activity with some supervision or reminding; (3) perform the activity with some human assistance; (4) perform the activity with human assistance most of the time; or (5) total assistance is needed each time the activity occurs. A plan of care is developed using the data provided from the ILA and other collateral sources.

Individuals with a primary disability that is physical and a secondary disability that includes other cognitive/mental and/or substance abuse disorders, could apply for the 1115 LTC Waiver. It is the case manager's responsibility to ensure that the individual is connected to appropriate services such as those offered through the mental health providers. In the few cases where individuals have requested to move from the Developmental Services 1915(c) Waiver to the DA&D 1915(c) Home-Based Waiver, we have held a case conference with the clients to discuss which waiver can best meet their needs. We will continue this practice.

- D. Please provide a scenario under Vermont's current eligibility and service delivery system (State Plan, nursing facility, HCBS, and ERC) to describe who is in which group and what services they receive now as compared with services under the demonstration.

NURSING FACILITY SCENARIOS

Scenario	Services under current System	Services under the 1115 Waiver
<p>A. <i>A. Mrs. Smith is an 89 year-old widow who lives alone has dramatically failed in the past 3 months. She cannot get to the bathroom when necessary because she is needs assistance to get out of bed or her chair. In those instances where she has managed to get up, she has fallen due to her weakness and unsteady gait. She is no longer able to dress and undress herself. She will wear the same clothing until her daughter arrives for her daily visit. She has lost weight. She is beginning to seem confused and forgetful.</i></p>	<p><i>Mrs. Smith would meet the Nursing Home Level of Care Guidelines and could apply for care in a nursing facility or enroll in the 1915(c) Waiver program if a slot were available.</i></p>	<p><i>Mrs. Smith would fall into the Highest Need group because she requires extensive assistance with one” late loss” ADL (toileting) and limited assistance in at least one other ADL (dressing). She would have the option of care in a nursing facility, Enhanced Residential Care Home or at home.</i></p>
<p>B. <i>Mrs. Jones is an 89 year-old widow who lives alone and has had changes in her ability to function at home in the past few months. Her overall functioning has declined, even with help from her daughter who visits frequently and Home Health Agency (HHA) aide services provided three times a week for assistance with bathing and personal hygiene, and home delivered meals. She has had a few falls with no significant injuries. However, as a result of the falls, she is reluctant to walk by herself. Because she has not been walking, her balance and gait have become increasingly unsteady and she frequently cannot walk more than a few feet without assistance.</i></p>	<p><i>Mrs. Jones would meet the current Nursing Home Level of Care Guidelines and could apply for care in a nursing facility or enroll in the 1915(c) Waiver program if a slot were available.</i></p>	<p><i>Mrs. Jones would qualify for the High Need group because she requires extensive assistance with walking on a daily basis and has a need for limited assistance with other ADLs. Assuming funds are available, she would be enrolled in the High Need group and the DA&D assessor would discuss care options, i.e. home, nursing facility, or Enhanced Residential Care. If funds were not available, she would be enrolled in the Moderate Need group so she could access case management, Adult Day and Homemaker services.</i></p>

ENHANCED RESIDENTIAL CARE SCENARIO

SCENARIO	SERVICES UNDER CURRENT SYSTEM	SERVICES UNDER 1115 WAIVER
<p><i>Mrs. Campbell. 85 years old and has been living in a residential care home for more than three (3) years. The residential care home is an approved Enhanced Residential Care Medicaid Waiver provider. Mrs. Campbell's care needs have increased to the point that she qualifies for nursing home care. Mrs. Campbell. would prefer to remain in her home, i.e. the residential care home.</i></p> <p><i>She needs extensive to total assistance with bed mobility, transfer, and toilet use. She needs limited to extensive assistance with all other ADLs.</i></p>	<p><i>Mrs. Campbell. applied for the Enhanced Residential Care Medicaid Waiver program and was awarded a waiver slot after a three-week wait. She continues to live in the residential care home and receive needed services through the ERC program. She receives 24-hour care (personal care, medication management, nursing assessment, recreational activities and supervision) from the care home and case management from the local AAA.</i></p>	<p><i>Mrs. Campbell would qualify for the Highest Need group and would immediately be eligible to receive the needed services in her setting of choice, i.e. the residential care home. She would receive the same services that she receives today, from the care home (24-hour care (personal care, medication management, nursing assessment, socialization activities and supervision) and case management from the local AAA.</i></p>

HOME-BASED SCENARIOS

Scenario	Services under current System	Services under the 1115 Waiver
<p>A. <i>Mrs. Baxter applied to the home-based waiver program while residing in a nursing home. She has a diagnosis of Alzheimers Disease. She was assessed as needing extensive assistance in toileting and limited assistance with three (3) other ADLs. She has memory problems and disruptive behavior on a daily basis.</i></p>	<p><i>Mrs. Baxter was immediately eligible for home based waiver and moved in with her daughter. The waiver program provides case management, 27 hours/week personal care and respite for her daughter.</i></p>	<p><i>Under the proposed system Mrs. Baxter would meet the criteria for the Highest Need group. She could choose to receive her services at her daughter's home. Her services could begin immediately and would be the same as in the current system.</i></p>
<p>B. <i>Mrs. Johnson is 79 years old. She lives alone. She has been receiving Homemaker services two times a week for cleaning, shopping and meal preparation. She has been fairly independent with her personal care. She slipped and fell on some ice, resulting in a hip fracture. After some time in the hospital and rehab center, Mrs. Johnson feels she is ready to go home. She now needs limited assistance with transfers, bed mobility and dressing. She needs extensive assistance with bathing and mobility.</i></p>	<p><i>Mrs. J went home with Homemaker services and Medicare LNA services. In less than two weeks it became clear that she needed daily assistance. She applied for the home based wavier program. Mrs. Johnson waited a month and a half for a waiver slot. She receives case management, daily personal care and Emergency Lifeline services.</i></p>	<p><i>In the proposed system Mrs. Johnson would meet the criteria for the High Needs Group. If funds were available she would be eligible to receive the same menu of services offered under the 1915(c) waiver today, i.e. case management, personal care services, personal emergency response system, adult day, respite, companion services and home modifications/assistive technology at home. She could also elect to receive meet her care needs in a nursing facility or Enhanced Residential Care Home.</i></p> <p><i>If funds were not immediately available, she would not be enrolled as a High Need member, but could enroll in the Moderate Need group and receive case management, Homemaker and Adult Day services while waiting to enroll in the High Need group. She would also continue to receive LNA services until funds became available so she could enroll as a High Need member.</i></p>

People who are on the current waiting list for the HCBS Waivers may be receiving:

- Unpaid/family care
- Home delivered meals
- Congregate meals
- AAA Older Americans Act case management
- Homemaker
- Senior Companion
- Housing and Supportive Services
- Dementia Respite
- Flexible Funds for to meet gap filling needs
- Adult Day (General Fund or Day Health Services – Medicaid State Plan)
- Medicare (physician, RN, LNA, PT, ST, OT, DME)
- Medicaid (physician, RN, LNA, PT, ST, OT, DME)
- Residential Care Home/Assisted Living Residence
- Inpatient hospital care
- Fuel Assistance
- Food Stamps
- General Assistance
- Lifeline – telephone bill reduction
- Essential Persons program
- 5310 transportation
- Medicaid transportation

18. The State proposes to implement presumptive eligibility.

A. If an individual is granted Presumptive Eligibility, what happens to that individual if s/he is later found to be (a) not eligible for Medicaid and/or (b) not meet clinical eligibility for the Demonstration?

Vermont would like to continue working with CMS to find a way of meeting our goal of initiating services to individuals as quickly as possible.

B. How will funds be recouped for services for those found ineligible? What will be the source of these funds?

See the response above.

19. Will the change in the resource limit (up to \$10,000) be calibrated for family size?

Vermont has decided to start with allowing an additional resource exclusion of \$3,000 for unmarried individuals who need long-term care and own their own home and it serves as their principal place of residence. The exclusion would not apply to individuals in assisted living, congregate housing or other living situations where space is rented. The exclusion is designed to provide the individual with funds to help cover home maintenance/repair or property tax and similar expenses. The resource exclusion will not be calibrated for family size because it will be an independent resource exclusion (like burial funds) and not tied to the general resource standard.

The intent is to review the efficacy of this exclusion after one year and see whether it is feasible to raise it, eventually getting to the original planned amount of \$10,000.

20. Why are persons with mental disorders are not included in the demonstration (i.e., screened out through the PASARR) as this disability group composes a sizeable number of persons inappropriately placed in nursing homes due to limited community-based services?

Over the years, Vermont has done an excellent job of ensuring that individuals with mental disorders (developmental disabilities and mental illness) do not end up being inappropriately placed in nursing facilities. Vermont is one of the least “institutionalized states in the New England region.” (See answers to #14 above for a description of the community-based programs available to these individuals.) Individuals whose primary disability which is physical, and a secondary serious mental illness, she/he may apply to the 1115 LTC Waiver; otherwise Community Rehabilitation and Treatment (CRT) services will be provided to those eligible for VHAP through the State’s other 1115 Waiver.

21. Please provide more detail regarding the “portion” of funds to be received by the DA&D upfront to provide case management.

We intend to dedicate some 1115 Waiver funds at the outset to providing case management for the Moderate Need group. We feel this step is important to proving our assumption that early intervention will delay more costly care and placement in a less independent environment. The estimated cost of case management for this group is about \$120,000 in Year 1.

22. Please describe the State’s experience with not reimbursing for nursing home residents’ care when such care is later assessed as not needed.

The State’s experience with ineligible individuals being admitted to nursing homes is that the occurrence is extremely rare. Major factors that limit this exposure are the lengthy experience of our nursing home providers with both the Vermont case mix system and the utilization review program. In the last 10 years only one facility was denied reimbursement for admitting an individual who was not clinically eligible. Individuals that improve after being admitted to a nursing home are discharged to community settings as appropriate.

23. The State provides Enhanced Residential Care Home/Assisted Residences Services. Please specify the services for which Medicaid pays and which are State-only services.

If an individual is enrolled in the Enhanced Residential Care Waiver, Medicaid pays for all the care services provided by the ERC or Assisted Living Residence, i.e. 24-hour care (personal care, medication management, nursing assessment, socialization activities, supervision, and case management services). No State-only services are provided. The State does not pay for room and board.

24. The proposal indicates that funds will be reserved for expanding case management to all needs groups. Please describe the other services that will be funded through this set-aside.

Individuals in the Highest and High Need groups will receive case management services as consumers do now under the current 1915(c) waivers. At start up, we anticipate offering case management, adult day and Homemaker services to individuals enrolled in the Moderate Need group. Once we see that additional funds become available as more enrollees chose home- and community-based services, we will be able to offer additional services, particularly to the Moderate Need group who could benefit from wellness programs and various healthy aging initiatives.

25. Expanding the responsibilities of the Office of the Long-term Care Ombudsman to home-based care appears to be a significant change. Please describe specific plans for expanding the function and funding of the Office.

There are currently 4.5 FTE regional ombudsmen, a .5 FTE volunteer coordinator, 19 certified volunteers, 7 volunteers in training and 2 volunteers who work on special projects. We would like to add at least two more individuals to the program. We firmly believe that this is an important investment in improving our quality assurance/quality improvement efforts. Funding for the expanded Ombudsman Program will be through the administrative cost portion of the Medicaid budget.

26. The State proposes to impose co-payments for certain home and community-based services. If co-payments are imposed, how does that affect individuals' access to services?

Vermont had proposed co-payments for the Moderate Need group. After working with staff from our Department of Prevention, Assistance, Transition and Health Access – PATH (formerly Social Welfare) on the details of implementing such as policy, we have decided that the procedures to assign and collect co-payments would simply be too cumbersome. Patient shares will be calculated for the Highest and High Need groups as they are today. Co-payments will not be used for those groups.

Individuals that we believe will be eligible for the Moderate Need group (Adult Day and Homemaker-type consumers) are used to cost sharing arrangements. Their payments are calculated using a sliding fee scale. We anticipate using this or a similar method for determining cost sharing for this group. Payments will be held to a modest amount.

27.

A. What communities are “underserved” for HCBS?

Vermont has 14 counties and over 250 towns, many with under 1000 people. The total population of Vermont is 608,627. It would be difficult to describe exactly which communities are “underserved” for HCBS; however, we can offer some examples of services that are lacking in key areas. Some areas of the state, such as the White River Junction area, need additional adult day services. Two small counties (Essex and Grand Isle) depend on neighboring counties to supply their adult day services. We have only two licensed assisted living residences, although more are planned. We have only one group

shared living setting for younger adults with physical disabilities. Home sharing and adult family care are fledgling programs in nearly every part of the state. Several counties could benefit from having additional Enhanced Residential Care beds and increased adult day capacity. Every part of the State is covered by a home health agency, an Area Agency on Aging and a community mental health agency.

B. How will this waiver address the needs of these communities?

As more people elect home- and community-based settings rather than nursing facility care, we will be able to use some of those savings to help develop and pay for alternative services as we have done since 1996.

C. What concrete efforts has Vermont taken to address capacity issues?

Since the Act 160 was passed in 1996, the reinvestment of funds into home- and community-based services as had a significant impact. Without our “Shifting the Balance” legislation, nursing facilities would have cost us approximately \$140,000,000 in SFY03. With Act 160, the cost was closer to \$98,800,000. Prior to Act 160, Vermont spent 88% of its public long-term care dollars on nursing facility care, leaving 12% for home-and community-based services. Today the proportions are 70% and 30% respectively, giving Vermonters greater choice among their long-term care options.

Dollars have been invested to:

- *create 685 additional HCBS Waiver slots (from 485 in 1996 to 1170 today);*
- *increase rates to Adult Day Centers, facilitating the development of increased capacity;*
- *increase the rates to personal care attendants under the 1915(c) Waiver Consumer/Surrogate Directed options;*
- *develop and support 10 community Long-Term Care Coalitions;*
- *increase wages to personal care attendants in the Attendant Services Program,*
- *provide addition dollars for the Attendant Services Program to reduce the waiting list; raise case management rates;*
- *develop and support the Housing and Supportive Services program in congregate housing settings;*
- *add additional Waiver slots; raise rates in the Enhanced Residential Care Waiver; provide flexible funds to fill critical service gaps not covered by other programs;*
- *increase the funding for home modifications by \$100,000.*
- *help underwrite the cost of developing a group residential setting for younger adults with disabilities who share their caregivers; and*
- *provide partial funding for a dementia respite program. In addition, Vermont has put significant effort into improving the recruitment and retention of caregivers.*

28. It appears that the 6 percent long-term care bed elimination commitment included in Vermont’s Act 160 in 1995 was not met. Rather, a 5 percent reduction occurred. Please provide

additional information on why 6 percent goal was not accomplished to help assess if this demonstration's objectives are attainable.

Act 160 set a goal of reducing the Medicaid nursing facility expenditures by the equivalent of 188 beds by the end of SFY00. Since Act 160 was passed, the number of nursing home beds in Vermont has decreased by over 300 and at any given time over 300 beds are vacant in the State. We have more than met the targets set out in Act 160.

29.

A. What are the State's specific goals for customer satisfaction improvement and initiatives for achieving these goals under the demonstration?

Since 1999, the State of Vermont has conducted an annual consumer satisfaction survey. This survey, conducted by ORC Macro, measures overall satisfaction with the key programs delivered by DA&D. The survey uses a random sample of consumers that meets the statistical precision requirements of no less than 5% standard error with a 95% confidence interval at the statewide level of analysis.

The survey measures overall consumer satisfaction with the Department's programs. The measures are:

Choice and control when planning services, quality of assistance, timeliness of services, service scheduling, communication with caregivers, reliability, degree to which services met needs, problem resolution, caregiver courtesy, how well people listen to needs and preferences, perceived value of services, impact of programs and service on consumers' lives and their ability to stay at home.

Consumers indicated overwhelming satisfaction and approval for the programs in which they participated. Satisfaction and approval ratings were consistently high across all measures. The percentage of consumers who felt long-term programs were a good value increased significantly (86.2%) from 80.8% in 2001. An overwhelming majority (92.3%) of consumers felt the help they have received from long-term care services had made their lives "much" or "somewhat better."

The survey also measures satisfaction with four specific programs. These programs include the Home-Based Medicaid Waiver, Attendant Service Program, the Homemaker program (state funded) and the Adult Day Program. Five program elements are evaluated. They are:

- *Satisfaction with the quality of services*
- *Services receive from program meet needs*
- *Caregiver treated them with respect and courtesy*
- *Know whom to contact with complaints or request*
- *Program provides services when needed*

The satisfaction level in these programs has remained high over the last four years. The highest level of satisfaction is with the caregivers. The satisfaction level is about 94% for all four programs. All other program elements showed a satisfaction level of 84% or above.

The State's specific goals for customer satisfaction improvement and initiatives for achieving these goals under the demonstration will be to maintain or improve the high level of satisfaction that has already been achieved. The demonstration will help to improve satisfaction in those areas where the satisfaction level was less than 82%. These include: amount of choice and control (80.7%), timeliness of services (81.9%), problem and concern resolution (77.7%). Consumers who are eligible and choose home and community-based services will no longer have to wait for a slot. They will now have a choice of staying at home or of going to a nursing facility. The demonstration will address the amount of choice and control because consumers will have a true choice over where they receive services at home or in a nursing facility. If our "Cash and Counseling" pilot proves to be effective and efficient, we will be able to put additional control in the hands of consumers. The issue of timeliness of services will be addressed because a state employee will do assessments, ensuring services will begin when needed for those individuals whose financial situations are transparent. Also money will be set aside to ensure agencies will receive reimbursement should state staff make an error in determining financial eligibility. Problem and concern resolution will be addressed because state employees will have a regional presence. This will ensure consumers are informed of all the options for care and will provide consumers with a local contact to voice concerns. If consumers have additional concerns the expansion of the Long-Term Care Ombudsman program will be available to receive and investigate complaints regarding services rendered under the demonstration.

B. How will case management agencies and providers be held accountable?

All case management agencies and their individual case managers are held to standards set by the State. Both sets of standards include steps for corrective action, and if necessary, decertification. Home health agencies are subject to surveys every three years by the DA&D Division of Licensing and Protection (DLP). DLP also investigates complaints filed by the general public and by other providers. DLP licenses all nursing facilities and Residential Care Homes, including Assisted Living Residences. These homes are surveyed at least annually and more often if complaints need to be investigated. Administrative penalties may be levied against both nursing facilities and Residential Care Homes and Assisted Living Residences (for Residential Care Homes/ALRs penalties may be from \$5.00/resident/day up to \$10.00/resident/day, which ever is higher) for a variety of reasons spelled out in the licensing regulations. Vermont has convened an 1115 Waiver workgroup, which is charged with expanding the quality assurance/quality improvement components of the demonstration, including sanctions for non-compliance.

C. What specific issues, identified in the most recent survey concerning quality of life, will this demonstration address?

The consumer satisfaction survey also includes a series of quality of life of questions. Two surveys are conducted; one for many of the Department's customers and one for the general Vermont adult population. The responses from the general Vermont adult population are then compared to those of the Department's consumers. The quality of life questions include:

- *Safety at home*
- *Safety in the community*
- *Mobility in the home*
- *Mobility outside the home*
- *Satisfaction with the amount of free time*
- *Satisfaction with the amount of contact with family and friends*
- *Support in an emergency*
- *Satisfaction with social life and connections with the community*
- *Concern about financial security*
- *Feeling valued and respected and*
- *Concern about going to a nursing facility..*

The only questions where there was no statistically different between the general adult Vermont population and the Department's consumers pertained to concerns about financial security (27%) and about going to a nursing facility (45%) in the future.

Results of the other quality of life measures differed by at least 5% between the two groups. Four of the Quality of Life measures differed substantially:

- *Mobility outside the home 92% of Vermont adults were satisfied with their ability get around outside their home as compared to 52.3% of the DA&D consumers; a difference of 39.7%.*
- *Satisfied with social live and connections to the community 83% of Vermont adults expressed satisfaction on this measure compared to 49.9% of DA&D consumers; a difference or 33.1%.*
- *Satisfaction with free time 87% of Vermont adults expressed satisfaction on this measure compared to 58.2% DA&D consumers; a difference of 28.8%*
- *Mobility inside the home 98% of Vermont adults expressed satisfaction on this measure compared to 70.3% of DA&D consumers; a difference of 27.7%*

This demonstration will address the following quality of life concerns:

The major concern for both the general adult Vermont population and the Department's consumers involves the possibility of going to a nursing facility (45%). This demonstration will provide consumers with more choice and opportunity to select where they will receive their long term care services. Consumers could stay at home or reside in an Enhanced

Residential Care Home or a nursing facility. Since consumers will have more choice, there should be less concern about residence in a nursing facility being the only readily available choice.

As more people are enrolled in the program and benefit from services, Vermont expects to see a higher level of satisfaction in other Quality of Life areas that address: safety at home (through assistive technology, home modifications, case management identification of needed repairs and provision of appropriate personal care), mobility outside the home as case management provides better coordination of transportation services; support in an emergency through case management services and development of networks of family and friends; concern about financial security through case management services which ensure that the enrollee is receiving all benefits to which she/he is entitled.

Cash and Counseling also allow individuals more flexibility in choice of services and providers, enabling them to decide which of the allowable investments (these are get to be determined) will help improve their quality of life.

30. Since the State is a recipient of a Real Choice Systems Change grant, please describe the role of CMS Technical Assistance providers in developing and implementing the proposed demonstration.

CMS Technical Assistance providers have been very helpful during the development of this proposed demonstration. Below is a list of the types of assistance provided. Assistance on workforce issues has been included because the workforce is critical to the success of the demonstration. The State will continue to seek the support from CMS technical assistance team once the implementation phase begins.

Technical Assistance from CMS Real Choice Grant Providers:

- Arranged for three speakers to attend a forum on December 10, 2002 organized by the Vermont Department of Aging and Disabilities, entitled "Best Practices and Trade Secrets: How to Recruit and Retain Quality Staff". A summary of the forum was prepared and posted on the NASHP web site with a link from the HCBS site. The summary was also disseminated to other state grantees. Speakers included: Robyn Stone, Institute for the Future of Aging Services; John McCarter, consultant from North Carolina; and Renee Pietrangelo, Executive Director of ANCOR in Alexandria, Virginia..*
- Arranged for lead staff from the Vermont Department of Aging and Disabilities to attend 1.5 days of meetings with the Maine grantee to discuss models for forming a caregiver association and to participate in a meeting for caregivers.*
- Arranged a conference call with staff from the Muskie School of Public Service, subcontractors to the Maine Real Choice grant, Di Findley, Director of the Iowa Caregiver Association and Debbie Barisano, Director of the Connecticut Caregiver Association concerning models for establishing a caregiver association.*

- *Organized a conference call with Vermont and other states on models for combining Medicaid long term care funding. Participating states included New Mexico, Utah, and Wisconsin. Following the call, a list of contacts was provided to the grantee including contacts in Delaware and Michigan. The Technical Assistance providers also reviewed federal statutes, regulations and the interim final Balanced Budget Act regulations, plus information about Colorado's §1915 (a) program. A memo and matrix comparing and contrasting different options for achieving Vermont's goals: §1115, §1915 (a) and (c) waivers and (1915 (b), (c) waivers with a prepaid health plan were prepared and disseminated. A summary of the call and tables comparing the options were prepared and sent to state agency officials and staff.*
- *Held a conference call with participation from GA, KY, MA, MN, WA and other experts to discuss options for creating equal choice through an 1115 waiver.*
- *Held a conference call with the grantee and staff from the Paraprofessional Healthcare Institute to discuss a wage and benefit survey.*
- *Supported travel for representatives of five New England states to attend a meeting to explore formation of a regional caregiver association.*
- *Arranged a call between the Vermont and Hawaii grantees to discuss strategies to form, structure and support advisory councils.*
- *Supported a meeting organized by the Maine Real Choice grantee on caregiver associations that included the Vermont grantee and association representatives from Connecticut, Maine, Massachusetts, New Hampshire and Vermont. The agenda included: presentations from each state (background and current activities on direct care/Personal Assistance Services worker associations and work on recruitment, retention, wage/benefit and training initiatives); a round table lunch to discuss the challenge; and an afternoon work session to identify the form and content of a New England regional structure for supporting common objectives for direct care/PAS worker associations.*
- *Arrangements were made for William Ditto, Director of the New Jersey Division of Disability Services, a demonstration site for Cash & Counseling, to attend a meeting in June 2003 on consumer directed programs organized by the Vermont Real Choice grantee.*
- *Responded to several Vermont specific issues. The first involved possible opportunities to adjust the current reimbursement system to provide incentives to create and support a team approach to care. The second involved helping the grantee find ways to combine multiple task forces (elders, physical disabilities, psychiatric disabilities, and developmental disabilities) by identifying states operating successfully and arranging for*

state-to-state assistance. Suggested states were Hawaii, Pennsylvania, and West Virginia.

- *Initiated contact with key sources who could assist in identifying survey instruments to obtain data on wages, benefits, turnover and other characteristics of the long-term care workforce across settings and providers. Provided materials submitted by the North Carolina grantee.*
- *Hosted three monthly follow-up calls with Vermont grantee and others to share information regarding the establishment of a direct support worker association.*

DRAFT VERMONT LONG TERM CARE CLINICAL ELIGIBILITY CRITERIA

HIGHEST NEED GROUP (11/14/03)

Step 1

- A. If nursing facility care is the individual’s choice, use PASARR screen. If the PASARR screen results in a determination that the individual may need active mental health treatment, **stop** and contact the Department of Developmental Disabilities and Mental Health for a STEP II PASARR Screen. **If no, continue to Step 2.**
- B. If home and community-based care is the individual’s choice, use the HCB screen on the back of this page. If the answer to any question leads to ‘STOP’, the individual is not eligible for the HIGHEST NEED GROUP. **If the individual passes all screening questions, proceed to Step 2.**

Step 2

Does the individual require extensive or total assistance with one or more of the following Activities of Daily Living (ADL), Toileting, Eating, Bed Mobility and Transfer; and *at least* limited assistance in any other ADL?

If yes, individual is eligible for the highest need Long Term Care (LTC) Group. If no, proceed to Step 3.

Step 3

Does the individual have a severe impairment with decision making skills **or** a moderate impairment with decision making skills **and** one of the following behavioral symptoms/conditions that is not easily altered?

- | | | |
|--------------|------------------------|--------------|
| Wandering | Physical abuse | Resists Care |
| Verbal Abuse | Inappropriate Behavior | |

If yes, individual is eligible for the highest need LTC Group. If no, proceed to Step 4.

Step 4

Does the individual have any of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis?

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

If yes, individual is eligible for the highest need LTC Group. If no, proceed to Step 5.

Step 5

Does the individual have an unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to conditions or treatments including but not limited to the following?

- | | | |
|-------------------|----------------------------|---------------------------------|
| Dehydration | Aspirations Chemotherapy | Dialysis |
| Internal Bleeding | Quadriplegia | Multiple Sclerosis Open Lesions |
| Aphasia | Oxygen Respiratory Therapy | Tracheostomy |
| Transfusions | Septicemia | Radiation Therapy |
| Vomiting | Pneumonia | Gastric Tube Feeding |
| Surgical Wounds | Cerebral Palsy | |

If yes, individual is eligible for the highest need LTC Group.
If no, the individual is not eligible for the HIGHEST NEED GROUP.

Home- and Community-Based Pre-Eligibility Screen

1. Is the applicant a Vermont resident and age 18 or over?
2. Yes No ***IF NO, STOP.***
3. Is the applicant at least 65 years of age, or does he/she have a physical disability?
Yes No ***IF NO, STOP.***
4. Does the applicant demonstrate a primary need for services due to a mental illness or developmental disability?
Yes No ***IF YES, STOP.***
5. Can the needs of the applicant be met with services other than the 1115 Waiver services?
If the answer is *YES* to any item, *STOP*.
 - Medicare or Medicaid services Yes No
 - Hospice Yes No
 - Day Health Rehabilitation Services Yes No
 - 1915(c) Waivers (TBI or DS) Yes No
 - Attendant Services Program Yes No
 - Other third party insurance Yes No
6. If the applicant is currently living in an institution, is there a reasonable expectation that housing can b found?

CONTINUE WITH CLINICAL ELIGIBILITY SCREENING on PAGE 1.

NOTE: If any of the above answers led to a “STOP”, then the applicant does not meet the “pre-screening” eligibility criteria for Home-Based 1115 waiver services.

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VERMONT LONG TERM CARE CLINICAL ELIGIBILITY CRITERIA

HIGH NEED GROUP (11/14/03)

Step 1

Use PASSAR Screen or HCB Screen as in HIGHEST NEED GROUP.

Step 2

- A. Does the individual require extensive to total assistance on a daily basis with any of the following ADLs: bathing, dressing, eating, toileting and/or physical assistance to walk?
- B. Does the individual require skilled teaching on a daily basis to regain control or function with ADLs, gait training, speech, range of motion, bowel and/or bladder training?

NOTE: Individuals who need lower levels of assistance may be eligible based on a combination of personal care and/or health factors.

If yes, individual is eligible for the HIGH NEED GROUP. If no, proceed to Step 3.

Step 3

Does the individual have impaired judgment or decision making skill that require constant or frequent re-direction ADLs or one of the following behaviors that require a controlled environment to maintain safety: constant or frequent wandering, inappropriate behavior, or aggression?

If yes, individual is eligible for the HIGH NEED GROUP. If no, proceed to Step 4

Step 4

Does the individual have any of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a less than daily basis and an aggregate of daily services including rehabilitation therapy?

Wound Care	Suctioning
Medication Injections	Ventilator/Respirator
End Stage Disease	Nasogastric Feeding
Parenteral Feedings	Severe Pain Management

If YES, individual is eligible for the HIGH NEED GROUP.

If NO to all of the above, the individual is not eligible for the HIGH NEED LTC GROUP.

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VERMONT LONG TERM CARE CLINICAL ELIGIBILITY CRITERIA

MODERATE NEED GROUP (11/14/03)

Step 1

HCB Screen (PASSAR not applicable as nursing home admission is not needed)

Step 2

Does the individual require supervision or any physical assistance three (3) or more times in seven (7) days with any single, or combination of, ADLs or IADLs ?

If YES, individual is eligible for the MODERATE NEED GROUP. If no, proceed to Step 3.

Step 3

Does the individual have impaired judgment or decision making skills that require general supervision on a daily basis?

If YES, individual is eligible for the MODERATE NEED GROUP. If NO, proceed to Step 4

Step 4

Does the individual require at least monthly monitoring for a chronic health condition?

If YES, individual is eligible for the MODERATE NEED GROUP. If NO, proceed to Step 5.

Step 5

Will the individual's health condition worsen if LTC services are not provided or if services are discontinued?

If YES, individual is eligible for the MODERATE NEED GROUP.

If NO to all the above, the individual is not eligible for the MODERATE NEED GROUP or for 1115 LTC services.

APPENDIX D

Current Nursing Home Level of Care Guidelines

Access to publicly funded nursing home services and Medicaid Waiver services is limited to those individuals who meet the eligibility criteria for nursing home care, as set forth by the Department of Aging and Disabilities' Division of Licensing and Protection, via the local Medicare Certified Home Health Agencies. The following Nursing Home Level of Care Guidelines have been used for over twenty years to determine if nursing home placement is necessary and appropriate for an individual. Because each individual is unique, no set of guidelines can encompass all variables to be considered when determining level of care. Nursing facilities and the DA&D Medicaid Waiver program each have additional criteria for admission.

REQUIREMENTS (A, B and C must all be met):

A. The individual must require at least one service on a daily basis including care and/or rehabilitation. An aggregate of different services, as outlined in I, II, and III below, adding up to a 7 day per week basis, is acceptable.

B. Such care (A, above) is most effectively provided in a nursing home or through DA&D Medicaid Waiver services. The individual may meet standards for continued eligibility if evidence in the individual's case record shows that the individual's health condition will worsen if s/he is required to leave the nursing home or if DA&D Medicaid Waiver services are discontinued. Such evidence must include documentation of previous unsuccessful discharge attempts or written consultation reports and attending physician opinions.

C. Assessment for health services needed, care planning, evaluation and monitoring of an individual's response to care and treatment is necessary and conducted by a registered nurse.

I. CARE AND SERVICES

The individual must require at least one service on a daily basis (A, above).

a. Activities of Daily Living (ADLs):

Bathing..... Moderate to total assistance required in the act of washing.
Does not include assistance getting in or out of the tub.

Bowel and bladder function.....Frequent incontinence of bowel and/or bladder.

Dressing..... Moderate to total assistance required.

Eating.....Must be fed or require more than encouragement to sustain adequate intake. Set-up assistance or cutting food is not included.

Ambulation.....Physical assistance to walk.

Transferring.....Physical assistance to move from bed to chair or from one surface to another.

b. Rehabilitation.....Skilled teaching required to regain control, function in ADLs; gait training, speech, range of motion, bowel and bladder training.

NOTE:

An individual who is assessed as requiring moderate to total assistance in ADLs will have MDS assessment (or Medicaid Waiver assessment) ADL codes of 3 or 4. Individuals who need lower levels of assistance may also be eligible, based on a combination of personal care and/or health factors.

II. CONDITIONS AND TREATMENTS

The presence of one or more of the following conditions and treatments may qualify an individual for nursing home care or for DA&D Medicaid Waiver services.

Intravenous fluids/Intravenous medications.....Any need.
 Medication injections.....Frequent titration, regulation or monitoring required for unstable medical condition.
 Pain management.....Daily severe pain.
 Pressure sores.....Stage III, IV, or multiple Stage II pressure sores.
 Airway suctioning.....Any need.
 Tube feedings.....Any nasogastric or new gastric feedings.
 Ventilator or respirator.....Any need.
 Wound care.....Application of dressings involving prescription medication and aseptic techniques for open wounds which may be infected or draining.

III. PSYCHOSOCIAL FACTORS

Within the limits of PASSAR and OBRA, psychosocial factors are considered. Psychosocial factors will be considered as justification for nursing home care services if the individual requires 24-hour care in order to meet health needs or if there is a determination that the individual's health will worsen if required to leave the nursing home facility or if DA&D Medicaid Waiver services are discontinued.

Cognition.....Impaired judgment and/or confusion, which requires constant or frequent direction with ADLs.
 Behavioral symptoms.....Constant or frequent wandering, aggression, and/or inappropriate behavior, which requires controlled environment to maintain safety.

**10/22/03 Comparison of Adult Day and Homemaker Participants
for Moderate Need Group**

	Adult Day %	Homemaker %
<i>NEED ADL HELP</i>		
Help Bathing	79	37
Help Dressing	73	18
Help with Bed Mobility	70	13
Help Toileting	70	13
Help Eating	69	13
Help Grooming	74	18
<i>NEED IADL HELP</i>		
Telephone	76	17
Transportation	82	45
Money Management	83	32
Laundry	84	67
Shopping	86	72
Medication Management	81	21
Food Preparation	86	51
Chores (heavy)	88	80
Housework	84	79
Taking out Garbage	84	66
<i>CHRONIC HEALTH CONDITIONS</i>		
Heart Problems	44	51
Arthritis	51	71
Diabetes	22	28
Cancer	9	10
Stroke	36	26
Emotional Problems	39	31
Breathing	24	31
Cataracts	25	24
Has Fallen	30	31
UTI's	36	29
Leg Swelling	32	49
Cognitive Impairment	56	12
Other	24	23

HOUSEHOLD MONTHLY INCOME

<\$695.00	25	44
<\$937.00	19	26
<\$1178.00	10	10
<\$1420.00	10	5
<\$1662.00	14	2

DECISION METHOD

By Self	24	55
With Family & Final by Self	28	34
With Family & Take Advice	20	6
Let Others Decide	18	1

LIVING ALONE

	Adult Day %	Homemaker %
Alone	26	79
With Spouse or Partner	20	9
Spouse/Partner with Child	4	1
With Child	22	7
Other	26	4

RATE OWN HEALTH

Excellent	8	1
Good	42	31
Fair	29	42
Poor	9	23

BAD HEALTH STOPS ACTIVITIES

Never	14	7
Sometimes	38	29
Often	21	35
Always	13	24

STAYED OVERNIGHT IN HOSPITAL (PAST YEAR)

Not at All	58	50
Once	22	25
2-3 times	12	15
3 + times	3	5

TIME IN RESIDENTIAL CARE

No	60	73
Yes	34	20

Employer/Agent Certification Form ATTACHMENT F

Directions: *This form is used to certify employers under the Home-Based Medicaid Waiver Consumer & Surrogate directed option and employers/agents under the Attendant Services Program. The employer/agent must meet all of the following standards to be eligible to direct services under the Home-Based Medicaid Waiver program or the Attendant Services Program.*

Complete all questions for a new employer/agent. Only #5 is required for annual reassessments with a previously certified employer/agent. Obtain information directly from the prospective employer/agent. If needed, information may be obtained from other relevant sources. The assessor must clearly record responses and provide detailed examples as needed.

Status (check one): New Employer/Agent Re-certification of Employer/Agent

Program (check one): Attendant Services Program
 Consumer Directed Home-Based Medicaid Waiver
 Surrogate Directed Home-Based Medicaid Waiver

Applicant/Participant Name: _____

Date: _____

Employer/Agent Name (if different than applicant/participant):

Employer/Agent Relationship to Applicant/Participant:

1. Communication and Decision Making: The employer/agent must be legally competent to make decisions, and must be able to effectively communicate verbally, in writing, or via assistive technology or other means.

- a. Does the prospective employer/agent have a legal Guardian?..... Yes No
- b. Does he/she have dementia, cognitive impairment, or mental retardation?..... Yes No
- c. Does he/she have the ability to communicate effectively..... Yes No
- d. Is he/she available on an on-going basis to act as the employer/agent..... Yes No

2. Knowledge of Disability and Related Conditions: The employer/agent must have knowledge of the applicant/participant's disability and related conditions, and must be able to describe this knowledge to others. This may include use of written information, lists, devices, etc.

- a. Is the prospective employer able to describe the disability and related conditions?..... Yes No
- b. Is he/she able to describe a plan to manage medications? Yes No
- c. Is he/she able to describe the use of assistive devices and/or adaptive equipment? Yes No

3. Knowledge of Personal Assistance Needs: The employer/agent must have detailed knowledge of the personal assistance needs of the applicant/participant, including ADLs and IADLs, and the ability to identify safe and unsafe practices and/or situations.

- a. Is the prospective employer able to describe a routine day and give examples of assistance needed? Yes No
- b. Is he/she able to describe meal preparation and dietary needs?.....Yes No
- c. Is he/she able to describe housekeeping needs?Yes No
- d. Is he/she able to identify current sources of paid and unpaid help? Yes No

4. Ability to Employ Personal Care Attendants: The employer/agent must be able to direct recruitment, interviewing, hiring, scheduling, training, supervising, and termination of PCAs. This may include support or use of materials, such as the Home Share VT handbook, manuals, etc.

- a. Is the prospective employer able to describe how to hire a personal care attendant? Yes No
- b. Is he/she able to describe how to train and supervise a personal care attendant? Yes No
- c. Is he/she able to describe what to do if the personal care attendant is sick or absent?..... Yes No

5. Ability to follow program requirements once on the program: At reassessment, the employer/agent must be able to understand and follow the requirements of participation in the program. This includes submitting all enrollment forms, submitting accurate timesheets as required by the payroll schedule. This may also include use of resources, such as a calendar, calculator, etc.

- a. Is the employer/agent able to describe basic program procedures? Yes No
- b. Has he/she demonstrated the ability to track hours worked, calculate totals, and understand pay periods?..... Yes No
- c. Has he/she completed and submitted accurate timesheets?..... Yes No
- d. Has he/she followed program rules and procedures? Yes No

SUMMARY - Assessor's summary of strengths and weaknesses identified above.

-CERTIFICATION DECISION -

The prospective / current (circle one) employer/agent:

_____ **does not** meet all standards to direct services at this time.

_____ **does** meet all standards to direct services with the understanding that this decision is contingent

upon continued eligibility and compliance with employer qualifications and standards, and must be reviewed at least annually.

Assessor/Case Manager - print name

Assessor/Case Manager's signature

Date

Agency Name

Phone #