March 2012

Commonwealth Medicine
UMASS MEDICAL SCHOOL
Applied Knowledge in Public Service

Vermont Choices for Care: Evaluation of Years 1-6

Final Report

Prepared by

Disability and Community Services

Cheryl Cumings, M.A.
Laney Bruner-Canhoto, Ph.D., M.S.W., M.P.H.

In cooperation with:

Bard Hill
Department of Disabilities, Aging, and Independent Living

Table of Contents

Executive Summary: CFC Evaluation Years 1-6 2
I. Introduction 6
II. Evaluation Framework 7
III. Evaluation Results and Discussion 10
Profile of CFC Enrollment 10
A. Information Dissemination 13
B. Access 15
C. Service Effectiveness 18
D. Experiences with Care 22
E. Quality of Life Outcomes 24
F. Applicant Lists 26
G. Budget Neutrality 28
H. Public Awareness of Long-Term Care 29
I. Health Outcomes 30
IV. Conclusions and Recommendations 30
References 34

Executive Summary: CFC Evaluation Years 1-6

In September 2010, the Department of Aging and Independent Living (DAIL) was notified by the Center of Medicare and Medicaid that a five year extension of the Choices for Care 1115 Demonstration waiver was approved. The Choices for Care (CFC) program is for adults (including older adults) with unmet long-term care needs. The waiver was designed to further shift the state's long-term care utilization and spending to community care. Several key design features were put in place to achieve this goal. First, the waiver brought under its oversight the entire continuum of long-term care services (home and community-based services or HCBS, enhanced residential care or ERC, and nursing facilities/NF). The program also encompasses HCBS delivery types such as self-directed care, surrogate-directed care, Cash and Counseling-based Flexible Choices, PACE, and traditional agency services. While CFC sought to increase access to community options for participants, the waiver was also designed to give priority to individuals at the highest level of need. Specifically, applicants meeting CFC highest needs had a choice of any long-term care setting without being put on a waiting list for enrollment. While applicants meeting high needs could qualify for the same amount and types of services as highest needs, they might experience delays in enrollment if funding availability were in question, i.e., if a high needs applicant list was active. Similarly, moderate needs participants, who are not required to meet nursing home level of need or financial criteria for Medicaid long-term care, could receive homemaker, adult day, and case management services, but could also be put on an applicant (waiting) list for services.

During the sixth year of CFC (October 2010 through September 2011), DAIL continued to contend with on-going state economic challenges. In response to a legislative directive, Act 68, Challenge for Change, DAIL actively participated in an initiative which called upon Vermont state agencies to explore creative solutions to decrease spending. DAIL developed new initiatives and continued to work on issues that have been identified in prior years such as:

- Exploring the establishment of an additional community setting, Adult Family Care.
- Expanding access to services by the implementation of a 'Waiver While Waiting' option.
- Assessing the impact on the service delivery system and financial commitments of the inclusion of non-medical providers as CFC HCBS providers.
- Exploring the use of a tiered reimbursement system for HCBS services.
- Utilizing the flexibility of the Consumer Satisfaction Survey to obtain participant perspectives on the impact of being dually eligible for Medicare and Medicaid on services and the impact of expanding CFC providers to include non-medical providers.
- Progressing towards a larger percentage of people being served in the community than in institutional settings; in eight counties, at least 50% of people receive support through home and community-based services.

Analyses of the sixth year of enrollment and HCBS participant survey data point to some consistent progress towards desired outcomes for CFC participants. As in previous years, the 2011 Vermont Long-term Care Consumer Survey (Richardson, Maurice & Madden, 2011) encompassed data from the Attendant Services program, the High Technology Home Care program, the Traumatic Brain Injury program and CFC services. Throughout this report, CFC services or CFC programs refer to: Personal Care, Homemaker, Adult Day Center and Flexible Choices.

Recognizing that the ratings were generally high in the 80% - 90% range, the consumer survey clearly shows that long-term support service participants' satisfaction with the services they receive was high. In keeping with previous evaluations, we present the overall ratings of the HCBS system in this section:

- *Information Dissemination*: Throughout the years of the waiver, DAIL has developed and continues to use its website to provide brochures, forms, regulations, reports and guidelines to case managers, providers and participants. CFC participants reported that their "choice and control in planning for services" was Excellent or Good (between 89% to 92%), indicating their ability to express preferences. This highlights CFC's ongoing work related to this outcome.

- *Access*: In 2011, for CFC programs, percentages of participants reporting that the "timeliness of services" was Excellent or Good ranged from 82% to 91%, with most programs showing a small decrease from last year. CFC should continue to work to ensure that participants receive CFC services in a timely manner.

- *Effectiveness*: In addition to the access measures, other data point to the impact CFC and DAIL have had on its ability to meet all levels of need in the community. Enrollment data highlight the ongoing trend of highest needs participants being increasingly served in HCBS and ERC as opposed to NFs Furthermore, the proportion of all highest and high needs participants supported in the community with HCBS, as opposed to nursing facilities, was 47%. For the highest needs participants, 42% were in settings other than nursing facilities, maintaining the gains CFC has made in this measure over six years. In addition to coordination efforts in years past, CFC instituted changes designed to improve coordination of services for the moderate needs group as they move between regions of the state.

- *Experiences of Care*: Satisfaction with CFC programs remains uniformly high with percentages ranging from 93% to 99%. Similarly, most CFC respondents (93% or more) reported Excellent or Good when asked about the "courtesy of others". Although these above measures were uniformly high, one concern is the decreasing rates of CFC service recipients indicating that staff worked with them to resolve problems, which was noted for all four programs. Though very few reported problems, many of these individuals who did report problems did not report that staff had worked to resolve the problem.

- *Quality of life:* In 2011, the percentages of CFC respondents who said that the help they received made their lives much better or somewhat better had increased as compared to 2010. The 2011 quality of life composite scores were stable compared to 2010 and showed that recipients of homemaker services had a lower rating than recipients of all other CFC services.

- *Impact of Waiting/Applicant List:* Although the high needs applicant list had been active most of the six years, in February 2011, the list was eliminated. In 2011, the moderate needs list was unfrozen allowing the provision of services to Medicaid participants (Edelman, 2011). Case managers who participated in a focus group shared that the moderate needs applicant list reflects a higher level of demand for homemaker services over adult day center.

- *Budget Neutrality*: DAIL continued to manage CFC spending in a way that stayed within annual appropriations, thus ensuring budget neutrality for the demonstration period.

- *Public Awareness:* DAIL has not embarked on a marketing campaign aimed at all Vermonters and so there are few direct measures of public awareness. Over 70% of HCBS respondents had spoken with someone about ways to get the help they needed. However, other measurement was not possible.

- *Health Outcomes:* Self-reported health, as a measurable and accessible indicator of health outcomes, declined slightly from 51% to 46% responding that health was excellent, very good, or good, compared to others.

Even though consumers are overall very satisfied with the program, there are areas which represent opportunities for improvements.

One major recommendation involves the actual evaluation framework. The framework and outcomes should be revisited at this time and revised to ensure that useful data are collected, summarized and presented within outcomes that are important to DAIL and CFC. A focused revision can ensure that the evaluation remains useful and flexible, resulting in findings that provide solid information about progress as well as actionable recommendations. Such a revision could include the addition of specific evaluation activities related to the moderate needs group (possibly under the Effectiveness outcome) to investigate the characteristics of this group and its progress in CFC.

Based on the findings, DAIL is encouraged to consider activities within the following outcome areas.

Information and Dissemination: With many of DAIL's brochures, forms and manuals on-line, DAIL should consider reviewing current online content and increasing awareness of the CFC materials available on its website to professionals, providers, participants and their families. Continued and enhanced coordination of efforts with the Information Referral and Assistance service, Aging and Disability Resource Center, and the Long-Term Care Clinical Coordinators (LTCCCs) can further this outcome and the public awareness outcome below.

Access: DAIL can work with its providers to ensure that everyone fully understands its new initiative, Waiver While Waiting. DAIL should continue to explore how to expand access through increasing numbers of participants who use the newer service options including Flexible Choices, PACE, 24 hour care and paid community spouse. Furthermore, with MFP and its Adult Family Care option, DAIL should continue to investigate whether this option for CFC could provide an avenue to improve access.

Experience of Care: Given DAIL's commitment to providing quality services, it is important that all participants report that their problems were resolved. DAIL should work with the staff at all levels that interact with consumers in the specific programs. With the data provided in the Consumer Survey, DAIL can identify the specific agencies through further review of the report.

Effectiveness: Effectiveness includes care coordination. One of the more prominent groups requiring care coordination is individuals with mental illness. In focus groups with long-term care professionals from hospitals, VNAs, AAA and HHA concerns about participants with mental illness and their access to CFC have been raised.

Quality of Life: The Consumer Survey measures program-level and component-level quality of life. Currently quality of life score have not changed significantly over the past two years and there is no difference between CFC program participants. We recognize that there could be a tension around the

allocation of resources for a program between ensuring that basic services are available versus a less tangible concept of quality of life. One option may be for DAIL to build on its tradition of engaging stakeholders and work with stakeholders to identify specific aspects of quality of life on which to develop and to implement a plan which can improve these focused ratings.

Public Awareness: Because DAIL has not implemented an informational campaign aimed at all Vermonters, moving forward, the time is now to revisit the utility of this outcome for CFC and DAIL. We recommend that DAIL determine if there is any benefit to implementing such a campaign.

Process and outcome evaluation data over the six years show some very promising results, such as the increase of HCBS setting vis-à-vis institutional settings in serving highest needs participants and the consistently high satisfaction rates of HCBS participants with multiple aspects of CFC services. An important note is that CFC and its priorities may be impacted by larger-scale changes in terms of health care reform, such as the movement toward a single payer and initiatives related to dually eligible individuals. As these changes are discussed and implemented, CFC will need to determine if and how its program and its logic model need to shift. In addition, in the coming years, particularly if the challenging fiscal climate persists, DAIL will need to prioritize limited resources. Like other states facing revenue shortfall, Vermont may need to determine how much it can invest in broader goals such as improving participants' general health and quality of life compared with investments in meeting basic needs, and to balance its commitment to quality with its desire to serve all eligible participants.

I. Introduction

DAIL was notified by CMS that the CFC waiver was approved for an additional five years in September 2010. The Center for Medicare & Medicaid (CMS) in its approval letter wrote that the CFC program:

- Promotes the objectives of the Medicaid program and the Americans with Disabilities Act by creating an entitlement to home and community- based services for a group with the highest need for care. Experience gained through this demonstration paves the way for other States seeking to reduce the institutional bias of Medicaid;
- Institutes a person-centered planning process by matching services to participants' needs and choices according to a person-centered assessment and options counseling process;
- Contains participant protections, incorporated into the Special Terms and Conditions of Approval, to ensure the health and welfare of program participants and continuous improvement of the demonstration program; and
- Contains an evaluation component that continues to measure the demonstration's effectiveness in expanding comprehensive home and community-based services and preventing the need for nursing facility care. (Semi-annual report, March 2011)

<u>CFC Background</u>

Wanting to enhance its efforts to making long-term support services as available in the community as in institutional settings, in October 2005, Vermont implemented Choices for Care, an 1115 Waiver Demonstration program. The purpose of the program was to ensure that older adults and people with disabilities have access to long-term support services in a setting of their choice from institutional to community. To achieve this goal, CFC encompasses the entire continuum of long-term support services. Today, CFC includes Home and Community-Based Services (such as adult day health, assistive technology, home modifications and personal emergency response systems), Enhanced Residential Care (ERC), nursing facilities, Consumer-directed care, Surrogate-directed care, a "cash and counseling" model through Flexible Choices, Program for All-inclusive Care for the Elderly (PACE), and Home Health Agency services.

To fully support the provision of CFC services, a three-tiered system was established in which individuals with long-term care needs were identified as: highest needs, high needs or moderate needs. Individuals identified as highest needs can select the setting which best meet their needs and are guaranteed services. Individuals who are identified as high needs may face a delay in access to services depending on the availability of funding, and may be placed on an applicant (waiting) list. Those individuals who are identified as moderate needs are below the level of care that would require nursing facility placement, may not meet the financial criteria for Medicaid long-term support services, and can receive limited homemaker services, adult day services and case management. Similar to the high needs group, moderate needs individuals may also be placed on an applicant (waiting) list (Bruner-Canhoto and Cumings, 2011).

This sixth year has been one of change. Within the first six months of the new waiver period, DAIL was able to eliminate the applicant/waiting list for High Needs Participants and to unfreeze the applicant/waiting list for Moderate Needs Medicaid participants. From its stakeholder meetings in preparation for the waiver

application, DAIL identified several activities and issues which would allow the CFC program to expand its Home and Community-Based Services. These topics include:

- Create a new community setting option called Adult Family Care
- Explore the expansion of CFC providers to include non-medical providers
- Develop a mechanism to allow participants to receive services while waiting for their financial eligibility determination

Through the broader context of state government, CFC was also impacted by a legislative directive, Act 68, Challenge for Change Initiative. The Vermont legislature called upon the state to work with its community partners to find new, creative and cost-effective ways of providing services. For CFC, this permitted a review of its contracts to focus on performance outcomes, the exploration of a tiered reimbursement payment system for services and the determination to include the Adult Family Care community setting as a housing option for participants leaving nursing facilities as part of Vermont's Money Follows the Person (MFP) grant (DAIL Challenge for Change Bi-weekly update, March 2011).

II. Evaluation Framework

To meet federal waiver requirements and assess their own progress, DAIL contracted with the University of Massachusetts Medical School (UMMS) in 2007 to serve as an independent evaluator. Each year since 2007, UMMS has produced an evaluation report that summarized major changes in CFC policies or procedures as well as initiatives or efforts CFC has undertaken, the impacts on participants and the long-term care system CFC has had thus far, and policy areas for Vermont policy-makers to focus on in the coming years. Like previous annual evaluation reports, the current report builds upon past evaluation data while focusing on the most recent year's (October 2010 through September 2011) evaluation results.

To guide all evaluations and policy analyses related to CFC, UMMS and DAIL developed a comprehensive evaluation plan. The evaluation plan was further refined through input from Vermont stakeholders and national long-term care experts at a roundtable discussion co-hosted by DAIL and UMMS in January 2008. During the first five years of evaluation reports, it was recognized that there were already reports and data about institutional settings, whereas a robust assessment of home and community-based services did not exist. Past and current evaluation reports, thus, focus on community-based consumers to fill that gap.

As the waiver embarks on its second, five year period, it is time for DAIL and UMMS evaluators to engage in a comprehensive review and revision of the current evaluation plan. The health care and long-term support service systems are being shaped by events which were not anticipated, even at the time DAIL submitted its waiver reapplication. Today, there is now the Duals Initiative, which will certainly impact CFC as over 90% of CFC consumers are dually eligible for Medicare and Medicaid. Additionally, just recently, AHS released its Strategic Plan, which will inform the DAIL Strategic Plan and both plans will undoubtedly impact the current and future course of CFC.

Furthermore, financial realities, structural changes and data limitations have created challenges to measuring every indicator as envisioned in 2008. Therefore, a review and revision of the evaluation plan will aid DAIL to ensure that the analysis of the impact of the CFC program continues to be useful. For the purposes of this report, the current 2008 evaluation plan is used; as reported, the evaluation

provides data and analysis for every outcome area (although not always in the exact method or extent planned in 2008).

The desired outcomes for CFC provide the framework for process and outcome evaluations of CFC. The evaluation is also shaped by the short and long term outcomes and corresponding questions identified in the Waiver application.

Short-term Desired Outcomes:

1. Information Dissemination - Choices for Care participants (and their authorized Representatives) receive necessary information and support to choose the long-term Care setting consistent with participant's expressed preferences and needs:

- To what extent did participants receive information to make choices and express preferences regarding services and settings?

2. Access - Choices for Care participants have timely access to long-term care supports in the setting of their choice:

- Are new Choices for Care participants or nursing home residents who seek discharge able to receive Choices for Care services in a timely manner?
- To what extent are Choices for Care participants receiving the types and amounts of supports consistent with their currently assessed needs?

3. Effectiveness - Participants receive effective home and community-based services to enable participants to live longer in the community:

- Is Choices for Care increasing in its ability to serve participants in all Choices for Care levels of need in the community?
- To what extent are participants' long-term care supports coordinated with each other for the purpose of providing effective care?
- To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the Demonstration period?

4. Experience with Care - Participants have positive experiences with the types, scope and amount of Choices for Care services:

- To what extent do Choices for Care participants report having positive experiences with the types, amount, and scope of Choices for Care services?

5. Quality of Life - Participants' report that their quality of life improves:

- To what extent did Choices for Care participants' reported quality of life improve over the Demonstration period?

6. Impact of Waiting List - Choices for Care applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g., nursing home, enhanced residential care, home care):

- To what extent does the implementation of a waiting list for the high needs group in Choices for Care have different impact on applicants waiting to access home and community-based services versus nursing facility services?

7. Budget Neutrality- Medicaid cost of serving Choices for Care participants is equal to or less than Medicaid and home and community-based services funding:

- Were the average annual costs of serving Choices for Care participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?

Longer-Term Desired Outcomes:

1. Public Awareness - Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and individuals have enough information to make decisions regarding long-term care:

- To what extent are Vermont residents who are hospitalized aware of long term care setting options at the time of discharge?
- To what extent are Vermont residents who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?

2. Health Outcomes - Choices for Care participants' medical needs are addressed to reduce preventable hospitalizations and long-term care needs are effectively addressed:

- To what extent are Choices for Care participants' long-term care needs being effectively addressed?
- To what extent are participants' medical needs addressed to reduce preventable hospitalizations?

Again, this evaluation report will provide evidence related to each outcome. However, in some cases, data are not available to address specific questions. In those cases, data were analyzed and are presented to describe progress or lack thereof made for that outcome, but not for a certain question. For example, in Impact of Waiting List, we discuss numbers of the waiting/applicant list, rather than other process and outcome indicators because much of those data were not readily available.

Data Sources and Analyses

To evaluate CFC, information was reviewed from previous policy briefs, minutes of the Advisory Group, DAIL's annual budget reports, Semi-annual reports to CMS, and monthly meetings with DAIL staff. From these sources, the Evaluators obtain information about the functioning of the program and stakeholders' perspectives.

To understand the implementation process of CFC and provide context for the evaluation, we analyzed Semi-Annual CFC Reports to CMS between October 2010 and March 2011 and DAIL Advisory Board Meeting Minutes between October 2010 and October 2011. We concentrated our reviews on information about year six implementation. The semi-annual CFC reports to CMS documented the changing environment in which CFC operated during this period. They also documented activities that took place at the state level. DAIL Advisory Board meeting minutes covered the range of programs or topics that DAIL oversees, with CFC being one of these programs. The Advisory Board members include consumers, consumer advocacy groups, a trade association, and individual providers. The minutes captured at a very high level some discussions, feedback, and concerns related to CFC.

We assessed CFC's progress with respect to outcomes by reviewing the following data sources:

- CFC HCBS Consumer Survey: Between 2010 and 2011, HCBS participant feedback was gathered by an independent survey contractor, Market Decisions, asking HCBS participants for their views on several aspects of CFC services, such as the choice and control in care planning, timeliness of service, and quality-related aspects of services. In addition, HCBS participants also described their general health and certain aspects of their quality of life. The survey also asked questions related to being dually eligible for Medicare and Medicaid and the potential impact of adding new providers. We reviewed survey data collected in fall 2011. Similar to the 2010 survey, the 2011 survey interviewed consumers of the long-term support service system including the Attendant Services, Traumatic Brain Injury and the High

Technology Home Care programs. It also provides data on specific CFC services such as the Adult Day Centers, Personal Care Services, Flexible Choices and Homemaker Services.

- CFC enrollment and application data: Enrollment data collected by DAIL, as part of the waiver administration, track the number of CFC participants, the CFC setting in which they were served, their CFC level of need, as well as high needs applicant list and moderate needs waiting list. In addition, DAIL tracks the number of applications to CFC by major CFC settings (nursing facility, ERCs, HCBS, and moderate needs group). Applications provide an indirect means of assessing general knowledge and demand for different long term care settings.
- DAIL calculations of CFC projected 5-year budget, annual appropriations, and actual spending: DAIL reports annual state appropriations and actual CFC spending summary data.
- Non-Medical Provider Policy Brief (DRAFT): We conducted key informant interviews with stakeholders involved in the provision and use of personal care, respite, companion and homemaker services to explore the structural and financial impact of expanding CFC providers to include non-medical providers.
- Focus group: We conducted a discussion with provider stakeholders to obtain their perspectives on the role of the Moderate Needs Group within the CFC program.

Table 1 displays the primary data sources on which our assessment of each desired outcome is based.

Table 1: Data Sources for Each Desired Outcome

	Data Sources for Process & Outcomes Evaluation		
Information Dissemination	HCBS Consumer Survey	Reports to CMS	Policy Brief
Access	HCBS Consumer Survey	Reports to CMS	Policy Brief
Effectiveness	HCBS Consumer Survey	Reports to CMS	CFC Enrollment Data
Quality of Life	HCBS Consumer Survey		
Experiences with Care	HCBS Consumer Survey	Stakeholder Feedback	
Impact of Waiting list	CFC Enrollment Data	DAIL Advisory Board Minutes	Focus Group
Budget Neutrality	DAIL Budget Reports	Reports to CMS	
Health Outcomes	HCBS Consumer Survey		
Public Awareness	CFC Applications Data	Reports to CMS	Advisory Board Minutes

III. Evaluation Results and Discussion

Profile of CFC Enrollment

In year six, there was an increase in the number of individuals enrolled in the CFC program. During six years of CFC implementation, total CFC enrollment steadily grew in the first three years, before leveling off. Just as most of the increases were largely attributed to expanded enrollment in the moderate needs group, the leveling off also appears due to the moderate needs group's decreases. These decreases (24% to 20%) seem to be a result of the ongoing use of a moderate needs applicant list.

Following the moderate needs group (which experienced the largest increase in enrollment over the six years), the high needs group had the second largest enrollment increase. The proportion of high needs enrollment of total CFC enrollment nearly doubled from year 1 to year 4 and remains relatively steady.

However, high needs enrollment, which exceeded moderate needs enrollment in year 1, fell behind moderate needs enrollment after the first year of CFC and, in year six, continued the trend from year four of constituting about slightly more than half of moderate needs enrollment.

The highest needs group numbers continued to hover around 3200 in real numbers, similar to years past. Because moderate needs enrollment and high needs enrollment grew, highest needs enrollment consistently fell as a proportion of total CFC enrollment. Although highest level of need participants still constituted the largest proportion of all CFC participants, in October 2011, CFC was serving over 30% in other need level groups. See Table 2.

Table 2: Point-in-Time Enrollment by Level of Need

	Moderate (%)	High (%)	Highest (%)	Total
11/05	2	7	91	3537
10/06	13	6	82	4004
10/07	20	12	68	4643
10/08	23	13	64	5014
10/09	25	11	65	5145
10/10	20	11	68	4774
10/11	20	13	67	4888

Source: DAIL
Numbers may not add up to 100 due to rounding.

In terms of enrollment by setting, given the historical institutional bias, nursing facilities have been and remain the setting that serves the greatest number of CFC participants. Data from October 2011, however, highlight the sustained downward trend of nursing home enrollment. From 2005 to 2011, nursing home CFC enrollment dropped from 66% to 52%. This trend was coupled with a trend toward higher use of HCBS and ERC settings, in which the percentage jumped from 34% to 47% over the same timeframe. See Table 3.

Table 3: Point-in-Time Enrollment of Highest/High Participants by Setting

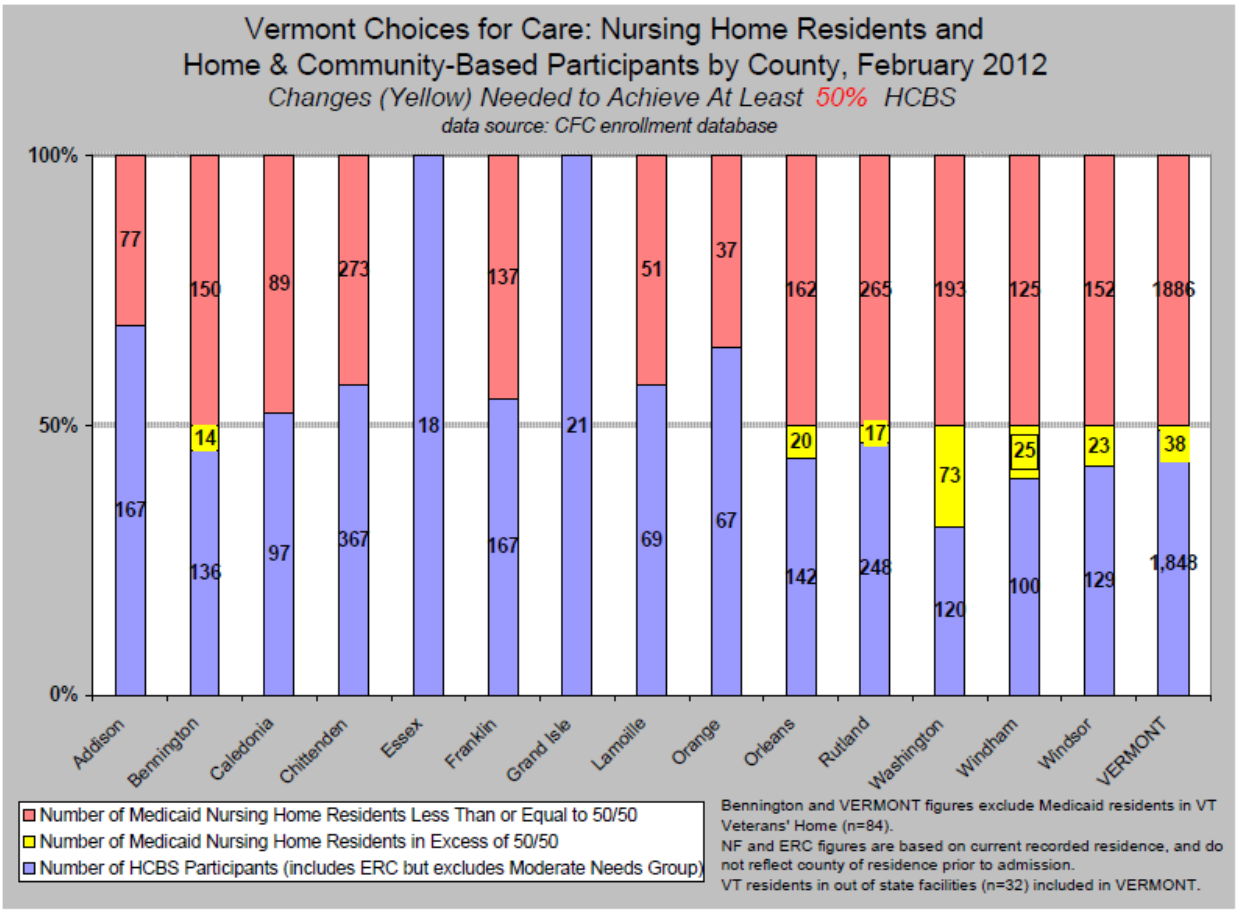
	NF (%*)	HCBS (%*)	ERC (%*)	Total # High/ Highest
11/05	66	29	5	3453
10/06	61	32	7	3497
10/07	53	38	9	3742
10/08	54	38	8	3847
10/09	53	38	8	3883
10/10	52	40	9	3776
10/11	52	38	9	3920

*Percent of total High and Highest Needs Groups in that month/year.
Source: DAIL
Numbers may not add up to 100 due to rounding.

Enrollment in HCBS and ERCs rose sharply in the first four years, with increases in ERC from 173 in October 2005 to 371 in October 2011 and increases in HCBS from 998 in 2005 to 1496 in 2011. These numbers represents a 114% increase for ERCs and a 50% for HCBS over the six year implementation of CFC. As the Renewal Application for the CFC Waiver noted, “Although nursing facilities continue to be the most frequent setting for participants, Vermont has significantly increased the number of Vermonters

receiving community-based services since implementing Choices for Care, while reducing the number of individuals receiving services in nursing homes." So, while the state has not reached a 50% split between nursing facility use and home and community-based services, data suggest that the state continues to progress towards this goal. In February 2012, eight counties had reached or surpassed the 50-50 goal, while the other areas were within 210 residents (combined) of that goal. See Figure 1.

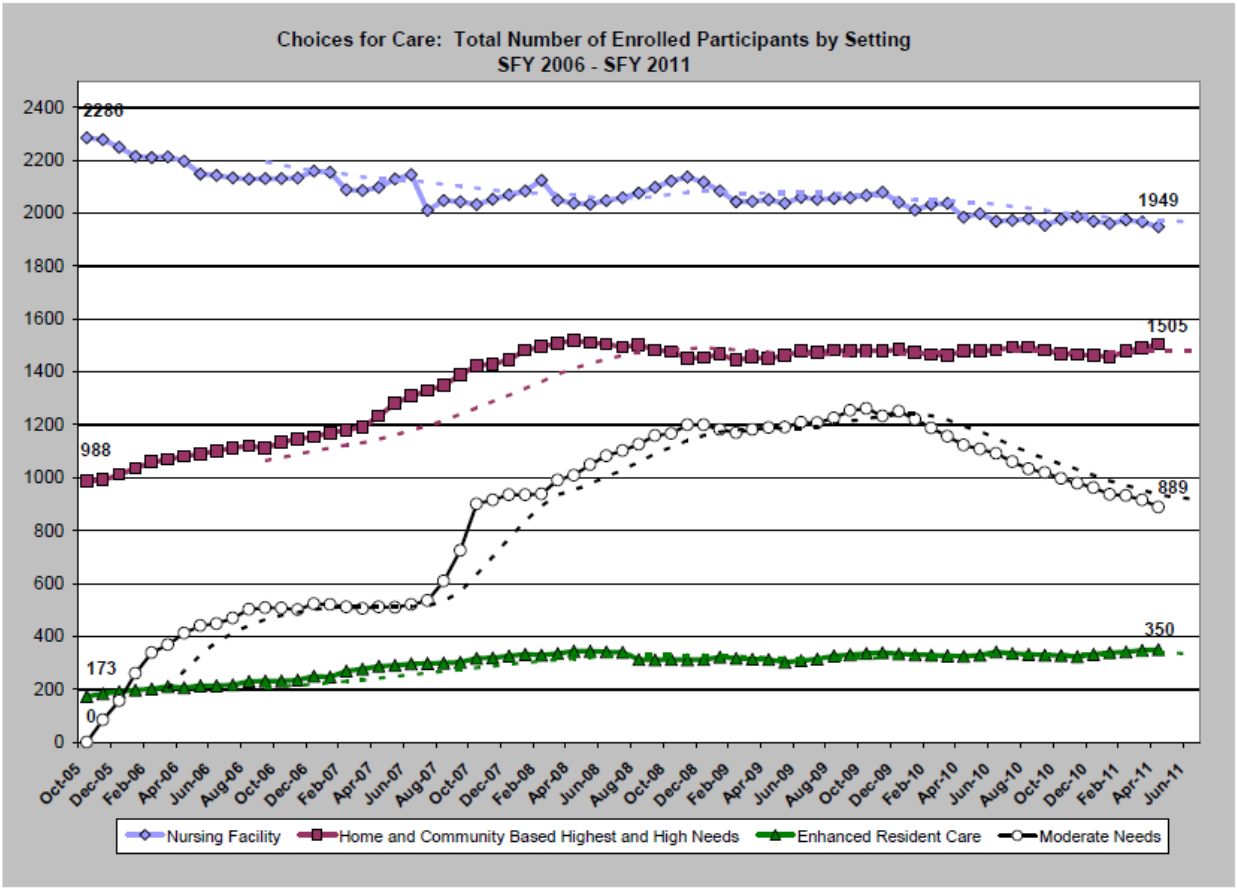
Figure 1. Nursing Home Residents and HCBS Participants by County, February 2012



Source: DAIL

In addition, Figure 2 on the next page highlights the diversity of settings currently serving individuals in CFC.

Figure 2. Total Number of Enrolled Participants by Setting



Data source: DAIL/DDAS SAMS database.

A. Information Dissemination

During the first five years of the CFC program, DAIL developed and used its website to provide brochures, forms, regulations, reports and guidelines to case managers, providers, participants and their family members. Because the website is one of the primary sources for information, we encourage DAIL to maintain its commitment to ensure that its webpage information is continuously updated.

Currently, DAIL's website is one source of information about the CFC program. There are other sources of information as well. In the 2011 Market Decisions survey, when consumers were asked how they first learned about long-term services, 22% responded friends. Hospitals at 17% and health care providers with 13% were the other common sources for information. The rate at which family and friends were sources of information remained the same from 2010 to 2011. However, although the specific causes for the change is not known, from 2010 there were slight increases in responses indicating that hospitals and health care providers were the source of information for long-term supports including, but not limited to, CFC.

Information dissemination not only reflects CFC's desire to provide consistent and critical information about CFC to potential clients, it also reflects CFC's interest in empowering clients in the making of choices that

affect their care. For the sixth year, 85% of all HCBS respondents[1] rated their choice and control as Excellent or Good (up from 81% last year). Ninety-two percent of respondents rated as Excellent or Good, how well people listen to their preferences and needs. From year five to year six, the results showed a slight, not significant, increase in HCBS participants' response to their involvement with planning for services and how well people listen to their needs and preferences. See Table 4. Note: There were few significant differences from 2010 to 2011 surveys. Instead, data are presented that highlight overall trends, progress or lack thereof. We do note the significant differences as such in the appropriate table. If there is no notation, the difference was not significant.

Table 4: HCBS Consumer Survey Indicators related to Information Dissemination

All HCBS Consumer Feedback	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Percent of participants ratings of "good" or "excellent" to survey items:						
"Choice and control when planning for their services"	86%	91%	89%	90%	81%	85%
"People listen to [their] needs and preferences"	86%	90%	90%	94%	91%	92%

Source: Market Decisions

By examining the specific CFC program, we better comprehend the extent to which participants are actively engaged and participating in the identification of services to meet their needs. For choice and control, a greater percentage of respondents with Personal Care, Homemaker or Adult Day Center services rated choice and control as Excellent or Good in 2011 as compared to 2010. However, Flexible Choices ratings decreased noticeably from 2010 to 2011. See Table 5.

Table 5: Percent of Participants Rating "Choice and Control" as Excellent or Good by Program

Program	2010	2011
Personal Care	84%	89%
Flexible Choices	88%	80%
Homemaker services	76%	81%
Adult Day Center	81%	84%

Source: Market Decisions

When it comes to people listening to respondents, a greater percentage of respondents with Flexible Choices, Homemaker or Adult Day Center services rated that as Excellent or Good in 2011 as compared to 2010. Personal Care respondents, however, did not rate "listening" as high, with a slight decrease in percentages from 2010 to 2011. See Table 6.

[1] For all overall data tables related to the survey, it is important to note that the overall "All HCBS Consumer feedback" in year five and six includes CFC participants as well as consumers of Attendant services, High Technology Home Care services and Traumatic Brain Injury services. Even though this response base is wider than the CFC program, the responses of participants from all of these programs offer an overall context within which specific attention can be given to the CFC programs. Therefore, for each dimension of the evaluation, we present data on the overall HCBS program and the specific CFC programs which include: Personal Care (Consumer-directed, Surrogate-directed, home health agency-directed), Adult Day Center and Flexible Choices.

Table 6: Percent of Participants Rating "Listen to Needs and Preferences" as Excellent or Good by Program

Program	2010	2011
Personal Care	95%	92%
Flexible Choices	85%	90%
Homemaker Services	87%	89%
Adult Day Center	90%	92%

Source: Market Decisions

B. Access

CFC is committed to providing services in a timely manner. Based on the 2011 survey, 85% as opposed to 84% of overall participants in 2010 rated the timeliness of their services as Excellent or Good. Similarly, in 2011, 90% of overall participants rated when they received services and care as Excellent or Good. This was a 2% increase from 2010. See Table 7.

Table 7: HCBS Consumer Survey Indicators related to Access

HCBS Participant Feedback	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Percent of participants ratings of "good" or "excellent" to survey items						
"Timeliness of services"	84%	90%	89%	88%	84%	85%
"When Receive Services or Care"	86%	90%	90%	92%	88%	90%

Source: Market Decisions

For the CFC programs, small changes in the rating of timeliness by program are shown. Most notably, there was a decrease in the percentage of Adult Day Center respondents, from 87% to 82%. See Table 8.

Table 8: Percent of Participants Rating "Timeliness" as Excellent or Good by Program

Program	2010	2011
Personal Care	86%	89%
Flexible Choices	92%	91%
Homemaker Services	84%	82%
Adult Day Center	87%	82%

Source: Market Decisions

For the CFC program, there are both decreases and increases in the percentage of participants rating of when they receive their services, how services fit into their schedule. Interestingly, the largest increase was in the Adult Care Center participants with an increase from 85% to 92%; possibly Adult Day Center services are not always timely, but when they are provided, they fit into respondents' schedules. See Table 9.

Table 9: Percent of Participants Rating "When Receive Services or Care" as Excellent or Good by Program

Program	2010	2011
Personal Care	91%	91%
Flexible Choices	91%	93%
Homemaker Services	84%	89%
Adult Day Center	85%	92%

Source: Market Decisions

DAIL seeks to ensure that existing service options meet assessed needs, a measure of access and effectiveness. Participants receiving HCBS have consistently indicated that their services "met their needs". In 2010, nearly 9 in 10 (88%) consumers rated the extent to which the services meet their needs as Excellent or Good. In 2011, the percentage for overall participants remained the same at 88%. See Table 10.

Table 10: HCBS Consumer Survey Indicators related to Effectiveness

HCBS Participant Feedback	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Percent of participants ratings of "good or "excellent" to survey item:						
"*Services meet daily needs"*	89%	91%	91%	95%	88%	88%

Source: Market Decisions

Within the four CFC programs, there was either no change (Flexible Choices) or increases in the percentage of individuals rating the extent to which the services meet their needs as either always or almost always. See Table 11.

Table 11: Percent of Participants Rating "Services Meet Daily Needs" as Always or Almost Always by Program

Program	2010	2011
Personal Care	92%	93%
Flexible Choices	90%	90%
Homemaker Services	85%	86%
Adult Day Center	83%	87%

Source: Market Decisions

DAIL continues to explore options for improving the service delivery system. In 2010, DAIL began the discussion of establishing another community setting called Adult Family Care. This option would allow participants who needed 24-hour care to remain in the community. This discussion was incorporated into Vermont's larger conversation about cost savings related to the Challenge for Change initiative. DAIL decided to make the Adult Family Care option a housing option for individuals coming out of nursing facilities in the Money Follows the Person (MFP) grant. In so doing, DAIL is implementing a new housing alternative. With the provision of this housing option, DAIL has the opportunity to determine whether an additional model of affordable and accessible housing will become available to CFC participants living in the community. As MFP becomes operational, DAIL should continue to explore how this housing model can be used by all CFC participants, not just those leaving nursing facilities.

In examining various actions to improve access to the CFC program, DAIL worked with the UMMS Evaluation Team to complete a policy brief on the inclusion of non-medical providers as CFC provider. Soon after the inception of the CFC program, DAIL developed a system in which the designated home health agencies contracted to exclusively provide personal care, respite, companion and homemaker services to participants. Although this model had been operational for many years, issues around access were raised. In the 2011 Vermont legislative session, Act 63 Sec. E. 300 (c) directed the Commissioner of the Department of Disabilities, Aging, and Independent Living (DAIL) to report to the House and Senate Committees on Appropriations, the House Committee on Human Services, and the Senate Committee on Health and Welfare by January 15, 2012 with recommendations regarding the scope of providers that the department may contract with to provide services under the CFC (Choices for Care) program.

In response to this directive, DAIL contracted with us, the external evaluation team. We conducted literature/ document reviews, analysis of several other states, secondary analysis of Market Decisions survey data and stakeholder interviews in order to explore and analyze the possible addition of non-medical CFC Home and Community-Based Services (HCBS) providers in terms of access, choice, cost and financial impact, and outcomes and quality. We found the following benefits and challenges associated with the expansion of CFC providers to include non-medical providers.

Domain	Benefits	Challenges
Access	o Increases the number of providers o Expands the options for consumers o May allow for the inclusion of providers who are willing to do things differently o Offers more staffing opportunities for times of day that are more difficult to cover (the evening, overnight and week-end).	o May complicate the system making it difficult for consumers and families to choose and access services o May decrease access if Home Health Agencies leave the market
Consumer Choice	o Gives the consumer more options o Allows the consumer to decide which agencies can meet needs the best o Empowers the consumer who selects provider to manage his/her services without feeling dependent on one organization o May encourage provider agencies to 'compete' for consumers by providing high quality and responsive services o Permits consumers in all locations to have options of service providers o Permits consumers who choose consumer-directed/surrogate-directed to have another alternative to agency services	o May create confusion for consumers through the addition of more organizations o May diminish consumer choice if Home Health Agencies leave the market
Cost/ Financial Impact	o Decreases service cost o May reduce some system costs if more people can be supported at home o May offer improvements in wages, benefits and working conditions for direct service workers o May create opportunities for Home Health Agencies to expand service reach by adding a non-medical provider entity to their agencies' menu of service options	o May create market that is not profitable enough for certain current Home Health Agencies o Compels the state to reevaluate the use of the provider tax o May increase some costs to state in administration and oversight of the system o May cause some consumers who self-direct to move to non-medical providers increasing some costs
Quality and Outcomes	o May offer an incentive for improved training for direct service workers o Increases access, one outcome of a high quality system, because consumers may be better able to receive all of the services they need o Increases opportunities to maintain a consumer at home (choice)	o Would mean developing and implementing standards and a quality monitoring system for a new set of providers.

Based on the findings, we recommended that Vermont open its CFC HCBS service delivery system to include non-medical providers. As noted in the report, we concluded that if the expansion is carefully and deliberately implemented, access and choice will be expanded and enhanced, costs will be controlled and quality will be maintained or improved.

C. Service Effectiveness

Service effectiveness relates to the ability of CFC to serve individuals of all levels of need in the community. In part, this outcome is shown through enrollment data as seen in Table 3, where 47% of CFC enrollees in High and Highest needs were in HCBS or ERCs. CFC has sought to enhance HCBS as an option serving persons at the highest level of need, an indicator of HCBS' effectiveness in the CFC evaluation plan. As noted, over the past six years, CFC has increased its enrollment substantially, with marked increases in HCBS. Currently, of all individuals at highest needs, the percentage of those participants being served either with HCBS or ERC is 42% and the percentage in nursing facilities is 57%, representing little change since last year. These numbers represent a continuation of the trend from November 2005 of decreasing numbers of highest needs participants being served in nursing facilities. This presents compelling evidence that CFC has been effective in enhancing and supports HCBS as an option for the highest level of need. See Table 12.

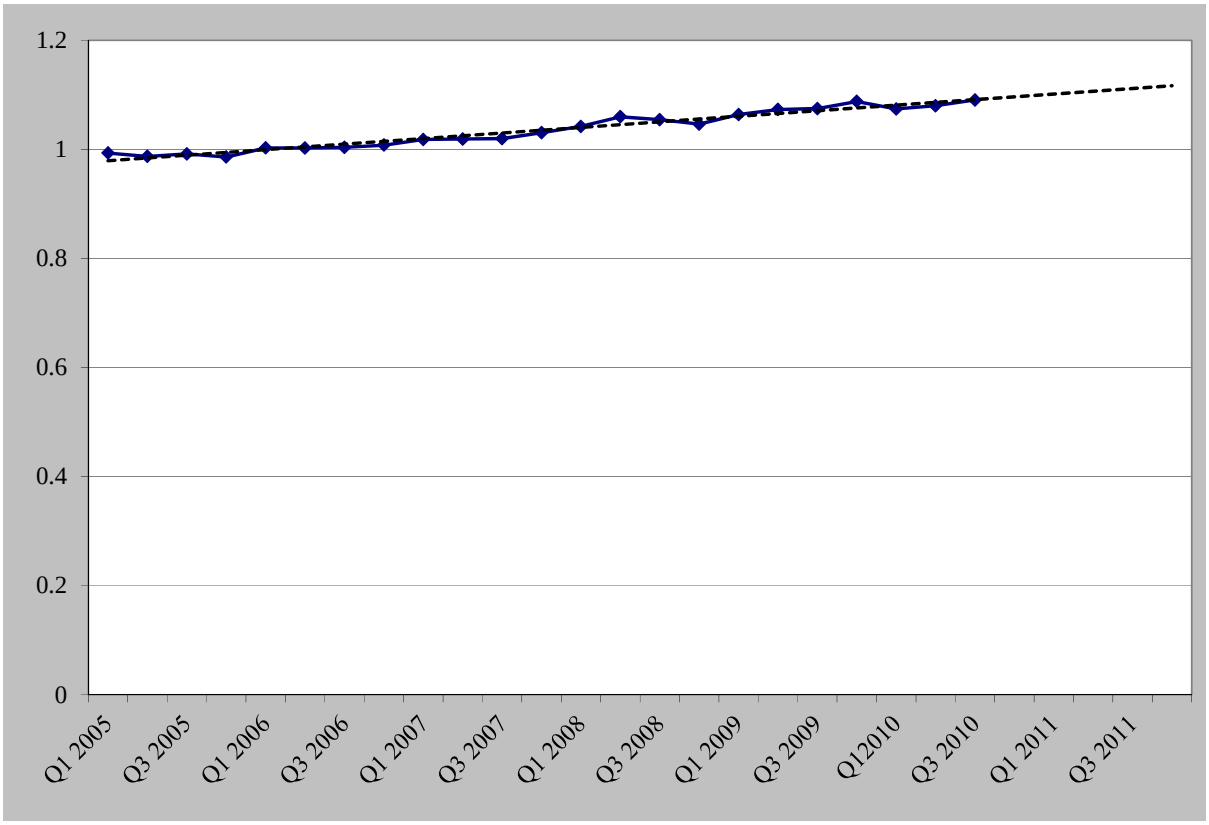
Table 12: Point-in-Time Enrollment of Highest Needs Participants by Setting

	NF	HCBS	ERC
November 2005	71 %	25 %	4 %
October 2006	65 %	30 %	6 %
October 2007	60 %	33 %	7 %
October 2008	60 %	33 %	7 %
October 2009	57 %	35 %	8 %
October 2010	57 %	43%	
October 2011	57%	34%	8%

Source: DAIL Data
Numbers may not add up to 100 due to rounding.

Another sign of the effectiveness of CFC can be seen in any increases in the acuity case mix for individuals residing in nursing facilities. As community options are seen as more and more viable for all levels of need, the acuity case mix in nursing facilities is expected to increase because more individuals with lower levels of need will be served in the community. Figure 3 shows that acuity levels are increasing, thereby providing evidence that CFC is effectively serving individuals in the community.

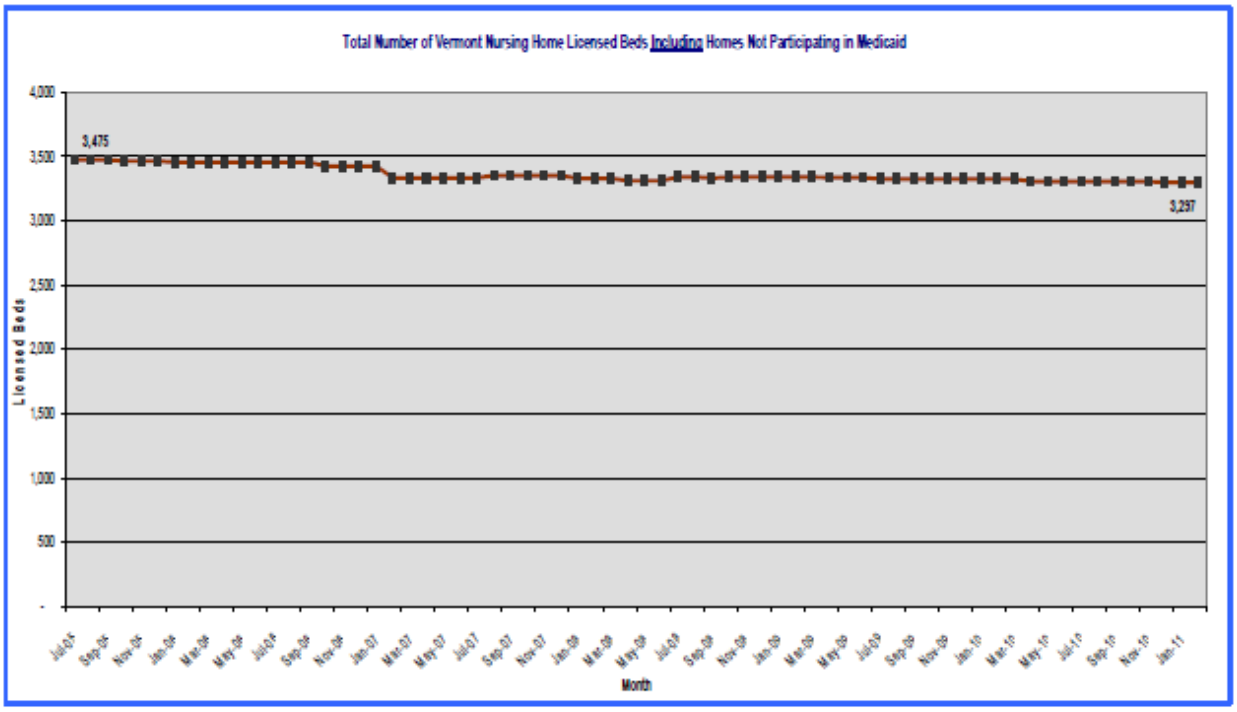
Figure 3. Average Nursing Facility Case Mix Scores by Quarter



Source: MDS, DLP

An additional sign of CFC effectiveness in meeting people's needs in the community can be found in the on-going closure of nursing facility beds. There has been a decrease in the number of people served by nursing facilities of 16% since October 2005. Monthly census data also show that the use of nursing facilities has decreased; the monthly census was 3,104 (all beds) and 2,145 Medicaid beds in July 2005 and in April 2011 the census was 2,844 and 1,778, respectively. This represents an 8% decrease in all beds and a 17% decrease in Medicaid beds. Since July 2005, there has been a decrease of 178 licensed nursing facility beds, representing a 5% decrease. See Figure 4.

Figure 4. Licensed Nursing Home beds in Vermont



Data source: DRS, using licensing information

Another indication of the effectiveness of CFC services may be seen in the program's applicant (waiting) lists. Although in October 2010, there were applicant lists for high needs and moderate needs participants, by February 2011, things had changed. DAIL was able to eliminate the high needs list and to unfreeze the moderate needs list for those individuals who receive Medicaid

Just as impactful on access to services were some policy changes for the moderate needs group. In February 2011, the Commissioner instituted the following operational changes for moderate needs participants:

1. Moderate needs participants would no longer have to reapply to the CFC program if they moved to another region of the state
2. Moderate needs participants, if, once in their new region, would exceed the cap of a provider agency, the funding from their previous agency could be transferred to the new agency to continue services.
3. People enrolled in one moderate need service will receive priority for another moderate need service.
4. The Independent Living Assessments are valid for twelve months from the date of the assessment unless it is determined that there has been a significant change.(Wehry, 2011)

With these policy changes, the CFC program continued to contribute to improving effective access for participants.

CFC not only encompasses services in multiple settings (e.g., nursing homes, HCBS) but also serves a participant population with diverse needs. DAIL has initiated efforts to meet service needs of "niche" groups within the larger CFC population, whether these participants are receiving HCBS or services in other settings. For example, as noted in previous evaluations, DDAS signed a Memorandum of Agreement

(MOA) giving priority to CFC participants who were also DMH clients. A discharge planning protocol was also established to facilitate transitions for individuals from the Vermont State Hospital and the correctional facility who could access CFC and non-CFC provider networks in the community.

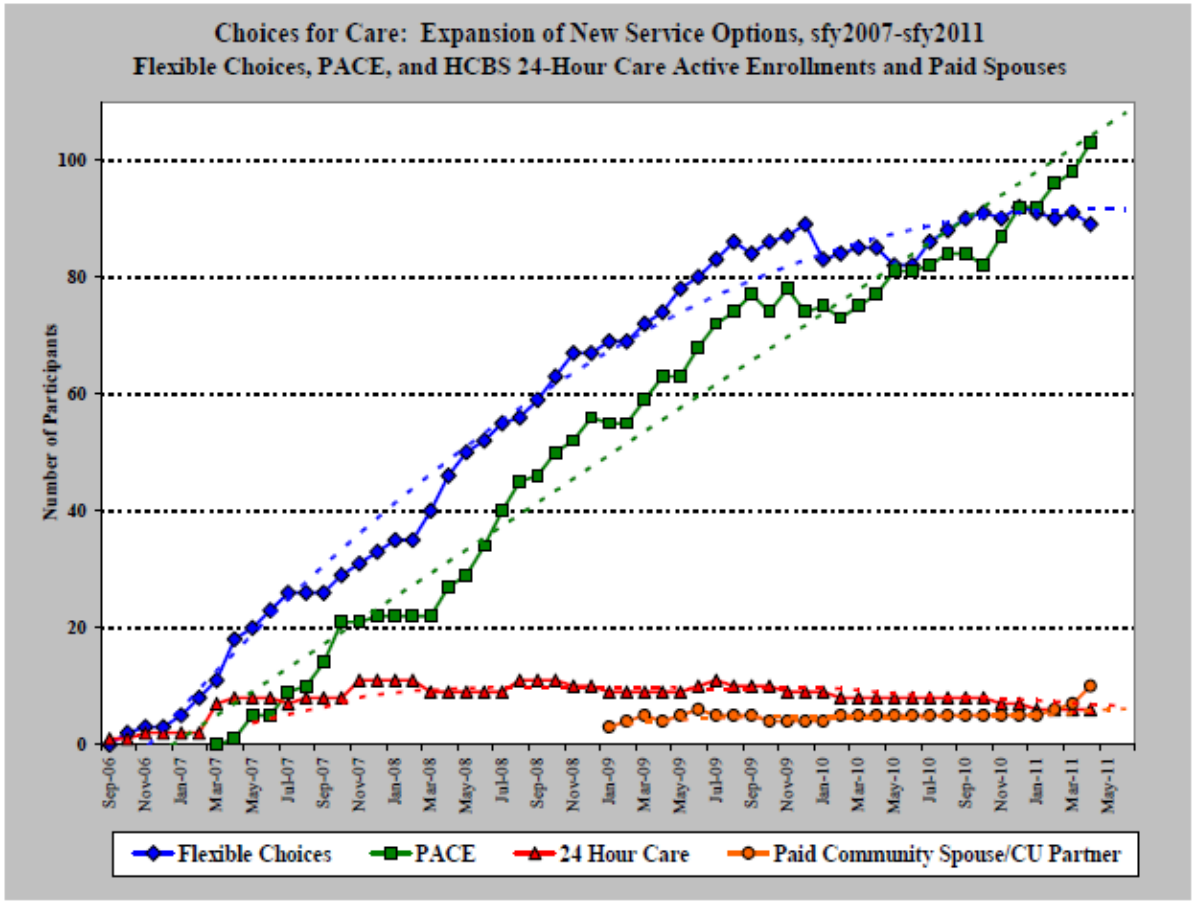
Yet, different stakeholders have expressed concerns about access to CFC services for individuals contending with mental illness. For example, a discharge professional at a hospital described a patient who remained in the hospital longer than needed because of the lengthy process to determine who could best meet the needs of the individual. As CFC participants contend with multiple disabilities including mental illness, it is important that the system has the capacity to respond to and integrate the needs of the whole person.

As noted in previous evaluation reports and providing further evidence of HCBS as an option, CFC has implemented and expanded several new service options. These options include:

- Flexible Choices: This Cash and Counseling-based option provides participants or their surrogates with a monetary allocation, known as an "allowance" to make a scope of purchases more expansive than any other CFC option. This option can support participants with long-term care needs that cannot be met by traditional services.
- Paying spouses: DAIL established guidelines to pay spouses as caregivers.
- PACE: Although this option has experienced numerous challenges such as staffing changes and slow enrollment, this is an evidence-based model that has been shown to improve health outcomes for its elder participants.
- Waiver While Waiting: This is a new initiative aimed at allowing individuals to receive needed services while the final determination on their financial eligibility is made. DAIL's goal is to increase access to services for its participants. As of September 2011, 6 people seeking HCBS, 2 people seeking ERCs and 11 individuals in nursing facilities have participated.

In May 2011, several of these options accounted for approximately 14% of highest needs and high needs individuals served in HCBS. See Figure 5.

Figure 5. CFC Participants in New Service Options



Data source: DAIL/DDAS SAMS database

D. Experiences with Care

The 2011 Consumer Survey found that the majority (93%) of all DAIL long-term care participants were satisfied with the services they received. By examining consumers' rating of satisfaction with specific program, a more complete understanding of the services is realized. Personal Care respondents were almost uniformly positive in their rating of satisfaction with the program (99%). In fact, the other three programs all had percentages of at least 93% and Personal Care and Adult Day Center had increased over 2010. See Table 13.

Table 13: Percent of Participants Rating Satisfaction as Very Satisfied or Somewhat Satisfied by Program

Program	2010	2011
Personal Care	98%	99%
Flexible Choices	97%	94%
Homemaker services	94%	93%
Adult Day Center	96%	97%

Source: Market Decisions

Ninety-three percent of all HCBS respondents rated the quality of the help they receive as Excellent or Good, compared to 89% in 2010. Similarly, consumers generally rated the quality of help received from

specific programs very high. Respondents from all four CFC services had percentages of 90% or higher and three had experienced a slight increase since 2010. See Table 14.

Table 14: Percent of Participants Rating "Quality of help received" as Excellent or Good by Program

Program	2010	2011
Personal Care	97%	97%
Flexible Choices	88%	91%
Homemaker services	89%	90%
Adult Day Center	94%	95%

Source: Market Decisions

Another experiences of care survey question involved how easy it would be for individuals to remain in their home without the services they receive. Eighty-one percent of all HCBS respondents indicated that it would be very difficult or difficult to remain in their homes without these services. By specific CFC program, there was a wide range in responses to this question. Specifically, individuals receiving Personal Care and Flexible Choices indicated that it would be difficult to remain in their homes without the services. Homemaker services respondents and Adult Day Center respondents were much less likely to respond that it would be difficult to remain in their homes. Given that many, if not most, of these respondents belong to the moderate needs group, this finding is reasonable and expected. See Table 15.

Table 15: Percent of Participants Rating "Ability to Stay in Home Without Services" as Very Difficult or Difficult by Program

Program	2011
Personal Care	90%
Flexible Choices	93%
Homemaker services	68%
Adult Day Center	72%

Source: Market Decisions

For individuals needing long-term supports, CFC caregivers constitute sources of important interpersonal experiences, given the nature of long-term supports. HCBS consumer feedback consistently indicated that workers were courteous and that service quality was Good/Excellent. Ninety-four percent of participants rated workers' courtesy and respect as Excellent or Good. The great extent to which consumers rate their treatment by their caregiver as courteous and respectful is further supported by the ratings given to individual programs. See Tables 16 and 17.

Table 16: HCBS Consumer Survey Indicators Related to Experiences with Care

HCBS Participant Feedback	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Percent of participants ratings of "good" or "excellent" to survey items:						
"Treat with Courtesy and Respect"	97%	98%	98%	97%	96%	94%

Source: Market Decisions

Table 17: Percent of Participants Rating "Treat with Courtesy and Respect" as Always or Almost Always by Program

Program	2010	2011
Personal Care	97%	98%
Flexible Choices	91%	93%
Homemaker services	95%	96%
Adult Day Center	95%	97%

Source: Market Decisions

Another aspect of experiences with care is how problems are handled and resolved. Eighty-six percent of all HCBS respondents rated as Excellent or Good how well consumers' concerns or problems are taken care of. When we reviewed the percentage of consumers who said they had a problem which occurred during the previous twelve months, by specific program, the percentage of people indicating that the program had worked to resolve the problem was less than the 2010 survey. Even though only a small percent in any program had a problem, "work to resolve" rates varied from 22% to 62% See Table 18.

Table 18: percentage of problems and problems resolved

Program	Percent with problem 2010	Percent of resolution 2010	Percent with problem 2011	Percent resolution 2011
Personal Care	16%	67%	11%	53%
Flexible Choices	19%	32%	15%	22%
Homemaker services	28% (sig. at 95%)	68%	17% (sig. at 95%)	62%
Adult Day Center	10%	52%	6%	48%

Source: Market Decisions

Although this issue affects only a small part of the participant population, the perception of unresolved problems (as one rudimentary measure of responsiveness by a service provider or a state agency) can potentially have negative impact. In as much as participants can express their delight with a program, they can also share their negative experiences. DAIL has worked hard to ensure that the CFC program provides quality services to its consumers: the fact that there is a segment who responded that their problem was not taken care of is an issue to which DAIL may wish to pay attention. The survey results are broken down by provider and could be used to identify specific issues or opportunities for improvement.

E. Quality of Life Outcomes

It is crucial that long-term supports be integrated into an individual's daily life in a way that enables the individual to continue to engage in activities that are deemed meaningful or that contribute to quality of life. One measure of quality of life related to long-term supports is whether or not respondents feel like the long-term supports they receive has made their life in general better. In 2011, 94% of HCBS respondents felt that the help they received had made their lives much better or somewhat better.

Looking at CFC programs separately, all four programs presented similar results with percentages of respondents (93% or higher) indicated that the help had made their lives much better or somewhat better. All four programs experienced an increase from 2010 to 2011 for this question. See Table 19.

Table 19: Has the help made your life better?

Program	2010	2011
Personal Care	94%	95%
Flexible Choices	95%	96%
Homemaker services	89%	93%
Adult Day Center	87%	94%

Source: Market Decisions

Since 2002, DAIL has been measuring quality of life of HCBS participants as well as the general Vermont population. For this sixth year of the consumer satisfaction survey, Market Decisions only examined the quality of life ratings among HCBS participants and between the various programs; Vermonters in general were not surveyed.[2]

Given this current survey methodology, we are presenting a correlation table, indicating the relationships between the various quality of life indicators and the programs. Higher numbers represent higher satisfaction. Primarily, Homemaker services respondents scored lower on the composite indicators, especially for social and emotional support. Homemaker services respondents also scored lower on the Service and Staff composite, which measures satisfaction with services and staff. Adult Day Center respondents rated their health much better than Personal Care Services, and somewhat better than the other two services. There were no substantial differences between the four CFC programs related to general life satisfaction. See Table 21.

Table 21. Quality of Life comparisons between CFC Programs

	Service & Staff Composite	Safety and Mobility Composite	General Health Composite	Interpersonal Composite	How often do you get the social and emotional support you need?	In general, how satisfied are you with your life?
Adult Day Center	2.54	1.74	1.85	1.69	3.22	2.00
Personal Care	2.58	1.76	1.58	1.65	3.26	2.03
Flexible Choices	2.55	1.70	1.76	1.68	3.17	2.05
Homemaker Services	2.45	1.68	1.75	1.57	2.83	2.03

Source: Market Decisions

The above scores remained mostly stable compared to 2010 numbers, with some decreases noted for Homemaker services (emotional and social support) and Personal Care (general health). Throughout the duration of the waiver, long-term care participants have evaluated their quality of life as less than other Vermonters. Even though there are many tensions between allocating resources to provide basic services or to ensure quality of life, given the importance of quality of life, we encourage DAIL to work with its stakeholders to identify issues and actions which can be taken to enhance quality of life for CFC participants. .

[2] Given the previous years' survey methodology, in past reports, we showed that HCBS participants (which included CFC participants) scored lower on the components of the quality of life scores as compared to Vermonters. They were less likely to feel a part of the community, valued and respected, satisfied with social life, satisfied with how they spend their free time, like they could get around their home and like they could get where they need to, when compared to Vermonters.

DAIL also implemented a recommendation from the 2010 Evaluation report to determine whether there was any association between length of disability and/or length of services received and a participant's quality of life rating. "A correlation analysis was run on the quality of life measures and the length of time (in months) a client has been signed up to receive services and the length of time they have been actually receiving services to test whether those with a recent disability have lower perceived quality of life. There is no evidence that the amount of time one has been receiving services, as a proxy for recent disability, is related to perceived quality of life" (Robertson, Maurice, Madden, 2011). See Table 22.

Table 22. Quality of Life Correlations with Time

	Service & Staff Composite	Safety and Mobility Composite	General Health Composite	Interpersonal Composite	How often do you get the social and emotional support you need?	In general, how satisfied are you with your life?
Number of months since signing up for services	.010	-.055	.012	-.041	-.065	-.031
Number of months since receiving first services	.009	-.029	-.018	-.037	.026	.002

Source: Market Decisions

F. Applicant Lists

High Needs Applicant List

As envisioned in the original waiver design, one mechanism that has helped CFC to stay within its budget has been the high needs applicant list. Individuals are maintained on the high needs applicant list only when an applicant list is active *and* as long as they continue to meet high needs clinical criteria. If their clinical profile meets highest needs criteria or if they meet any special circumstances for enrollment (e.g., loss of primary caregiver), they would be enrolled into CFC as a highest needs participant or special circumstance participant, respectively.

When CFC began in 2005, there were 241 persons on the 1915c waiver waiting list (this included both highest needs and high needs). With the commencement of CFC, all individuals who were on the waiver's waiting list were gradually enrolled over the first few months, even though the high needs applicant list continued to be active between October 2005 and December 2006 for new applicants. The high needs applicants list eventually fell to zero in May 2007. In February 2008, the high needs applicant list was reinstated and remained active through October 2010, with 30 people on the list as of October 2010. However, by February 2011, there was no longer a High Needs applicant list. Everyone on this list became a fully enrolled CFC participant.

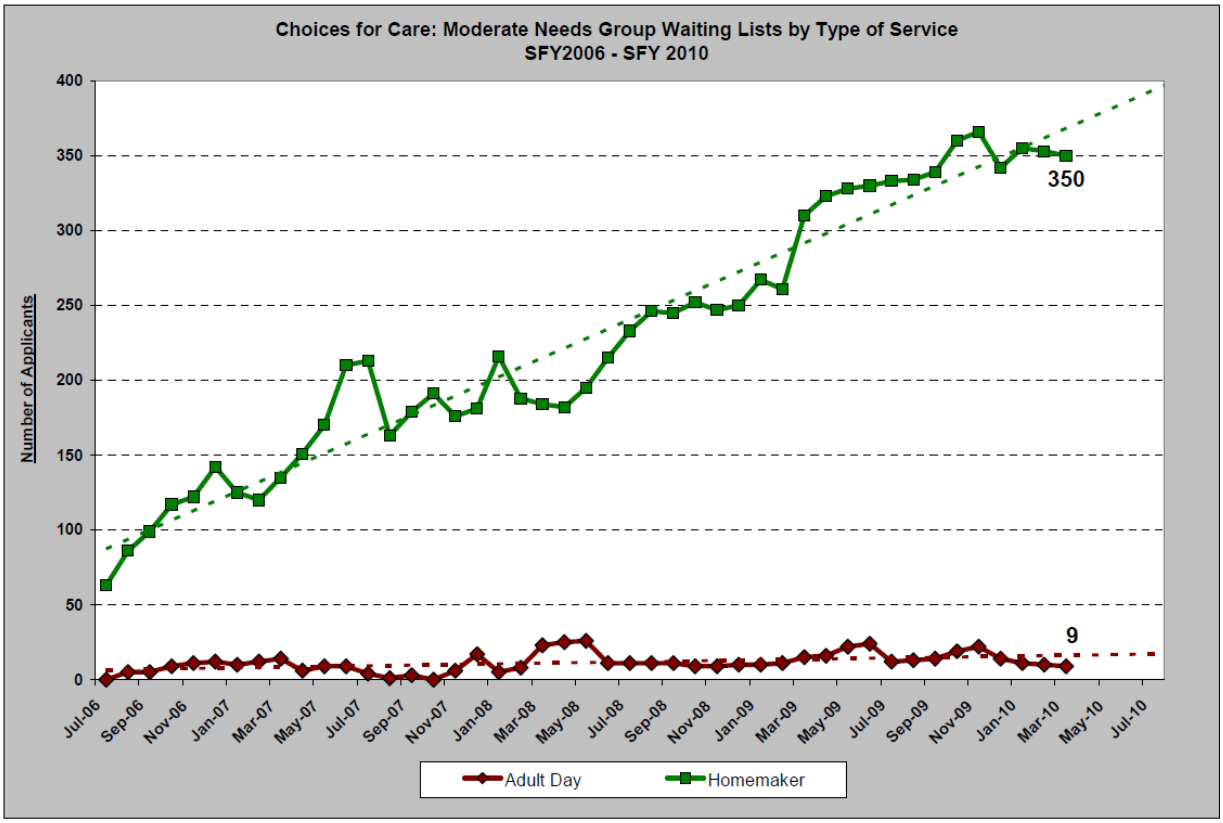
Moderate Needs Waiting Lists

The moderate needs group represents an "expansion" group that CFC sought to support in order to prevent or delay nursing facility entries. To be eligible for moderate needs supports (case management, adult day, and homemaker service), an individual could be below nursing facility level of care and could exceed the

financial threshold for Medicaid long-term care. As the waiver progressed, moderate needs funding came to serve participants that CFC designers had not originally envisioned. The number of moderate needs participants has also exceeded the anticipated maximum cap of 500 as well. Specifically, moderate needs participants came to include some individuals meeting high needs clinical criteria and financial criteria for Medicaid long-term care but were on the high needs applicant list. This group also includes some people who meet highest needs group clinical eligibility, but are either not eligible for long-term care Medicaid or want to avoid estate recovery requirements. This is consistent with providers' feedback that "moderate needs" do not properly describe some of their service recipients.

As shown in the figure below, there is more demand within the moderate needs group for homemaker and adult day services than either funding or provider capacity can meet, mirroring findings from previous years. The numbers of people on applicant lists for both services have remained steady over the past couple of year for adult day services; however homemaker services have continued to increase in demand, possibly highlighting the lack of entitlement for homemaker services. See Figure 6.

Figure 6. Moderate needs applicant list



Data source: waiting list reports from homemaker and adult day providers

The professionals who participated in the focus group[3] about CFC participants confirmed these numbers. One focus group participant related a situation of an individual who was about to be evicted and to become homeless. However, with Homemaker services, specifically someone coming in to help the individual keep

[3] The focus group members included staff of Area Agencies on Aging, Home Health Agencies, Adult Day Centers and Councils on Aging, all agencies involved with the provision of CFC services to aid Vermonters to remain in the community.

the apartment clean and pick up groceries, the participant has been able to continue living in the community. In another situation, a case manager described a participant who is 96 years old and was able to continue living in the community with the assistance of homemaker services.

The moderate needs applicant list represents measures of unmet need to some extent. However, these measures are only snapshot measures of demand and do not necessarily reflect the actual need for services. Some individuals may need CFC services but are never placed on an applicant/waiting list because they don't apply, they don't know to apply, they are able to piece together services to meet their needs to a more or less adequate degree or there is some other reason.

G. Budget Neutrality

Since its implementation of the Waiver, DAIL has effectively used its state appropriation to provide services. Despite all of the economic challenges confronting the state, the CFC program maintained its budget neutrality. Previous changes (documented in past evaluation reports) along with maintaining active high needs and moderate needs applicant lists appear to have helped control spending in an uncertain financial environment. At the end of year six, CFC spending was below appropriations by a wide margin, wider than any other year. Table 23 represents CFC Long-Term Care appropriations and spending only. Table 24 represents CFC appropriations and spending including Acute Care.

Table 23: CFC Long-Term Care

Choice For Care: Long-term care	SFY06	SFY07	SFY08	SFY09	SFY10	SFY 11
Appropriations	$141,783,616	$147,512,534	$163,921,443	$174,191,109	$174,214,857	$178,292,433
Actual Spending	$140,087,565	$147,869,913	$165,392,741	$171,852,746	$169,319,338	$165,455,926
% Difference between Actual Spending and Appropriations	1.20%	-0.24%	-0.90%	1.34%	2.81%	7.75%

Source: DAIL Business Office

Table 24: CFC with Acute Care

Choices for Care (with acute care)	FFY06	FFY07	FFY08	FFY09	FFY10	FFY 11
CMS Projections	$205,361,772	$204,107,689	$224,585,803	$253,729,888	$279,323,076	$331,150,864
	SFY06	SFY07	SFY08	SFY09	SFY10	SFY 11
Appropriations			$189,793,638	$202,456,746	$199,235,075	$209,553,531
Actual Spending	$154,787,921	$169,555,756	$190,510,654	$197,581,468	$194,617,477	$191,968,715
Actual Spending as a % of CMS Projections	75.37%	83.07%	84.83%	77.87%	69.67%	57.97%
% Difference between Actual Spending and Appropriations			-0.38%	2.41%	2.32%	9.16%

Source: DAIL Business Office

H. Public Awareness of Long-Term Care

One of CFC's long-term goals has been to increase general Vermonters' awareness of long-term care options, analogous to the goal of the "options education" that LTCCCs conduct with new CFC participants. Certainly, DAIL has engaged in targeted efforts through the Information Referral and Assistance service, ADRC, and the LTCCC. However, from discussions with DAIL, we know that the agency has not implemented a formal outreach or marketing plan aimed at increasing Vermont residents' awareness of the CFC program.

Even though DAIL has not actively pursued a public awareness campaign, CFC participants' responses to Consumer Survey questions about how they learned about getting help suggests that some information is reaching the public. Seventy percent of HCBS respondents indicate they have spoken with someone about ways to get needed help with daily activities and 91% were satisfied with the information they were provided. However, two other measures of public awareness do not show widespread knowledge. A majority of respondents (71%) indicate they are not at all or not very familiar with the LTC ombudsman program. Forty-six percent are very or somewhat familiar with the Adult Protective Services program.

The measures related to this outcome have mainly been general knowledge questions in surveys (see above) and proxy measures related to CFC applications[4]. We have relied on alternate measures because

[4] The applications data constitute one indirect source of data on Vermonters' knowledge/desire of long-term care settings at the time when they look to Medicaid to support their long-term care needs. In the first six months of the six year, there were 1592 applications, somewhat below pace of the previous five years' average (3704). During the first four years, the number of applications to nursing facilities and that of applications to HCBS were fairly close, with HCBS trailing nursing facility applications by about 4% to 9%. In the last two years, the gap has widened with between 43-44% of applications to nursing homes and 24%-27% to HCBS. In the first half of year six, there were 678 applications to nursing homes, 387 applications to HCBS and 97 to ERC. HCBS as a percent of the total remained steady, although decreasing slightly. ERC applications remained steady, while applications for the moderate needs group remained extremely low, mostly likely due to the enrollment freeze.

specific data on general Vermonters' knowledge have not been available. However, in part, this reliance on these measures has been due to the fact that DAIL and CFC have not implemented any specific activities on public awareness and it has been challenging to access appropriate data. As the CFC program continues, DAIL must determine whether the goal of developing a specific public awareness campaign for all Vermonters is the best use of its resources.

I. Health Outcomes

Within the past two years, HCBS participants' self-assessment of their general health has increased from 46% to 51% of HCBS participants reporting their "general health" as "good", "very good" or "excellent". As DAIL participates in AHS efforts to improve and to coordinate services, we encourage DAIL to ensure that the health status of CFC participants is included.

Over 85% of general Vermonters in 2008, 2009 and 2010 reported their "general health" as "good" or better. CFC participants have more chronic health conditions including disabling conditions than the general Vermont population, and therefore it is not surprising that their reported general health would be less "good". Although no data were collected on general Vermonters in this year's survey, it is reasonable to assume that disparities continue to exist.

IV. Conclusions and Recommendations

Overall, available data have indicated that CFC continues to be highly effective with HCBS participants, most of whom reported being satisfied with various aspects of the care experiences, e.g., choice and control in planning, quality of services, and timeliness of services. Specifically, data for the nine outcomes show:

- *Information Dissemination*: HCBS participants reported that their "choice and control in planning for services" was Excellent or Good, indicating their ability to express preferences. For CFC programs, this percentage ranged from 89% to 92%, again highlighting CFC's ongoing work related to this outcome. Throughout the Waiver, DAIL has developed and continues to use its website to provide brochures, forms, regulations, reports and guidelines to case managers, providers, participants and their families. Additionally, HCBS participants reported that friends, followed by hospitals and health care providers were sources of information.

- *Access*: In 2011, 85% of HCBS participants consistently reported that the "timeliness of services" was Excellent or Good. For CFC programs, percentages ranged from 82% to 91%, however, most programs showed a small decrease from last year, indicating that CFC needs to continue to work to ensure that participants receive CFC services in a timely manner.

At the same time, the numbers of applications for which the setting is "undetermined" continue to rise, from 3% to 23% of all applications. "Undetermined" applications mean applications that either do not indicate a setting being applied for or indicate multiple settings being applied for. There is, in fact, no requirement that an applicant determine a setting upon application. As a result, these undetermined applications may mean that applicants are not making decisions about an anticipated setting, in effect, keeping options open through clinical eligibility processes. Thus, this percent of undetermined applications may suggest that individuals do not necessarily equate long-term care with nursing facility care.

- *Effectiveness*: In addition to the above access measure also indicating effectiveness, other data point to the impact CFC and DAIL have had on its ability to meet all levels of need in the community. Enrollment data highlight the ongoing trend of highest needs participants being increasingly served in HCBS and ERC. Furthermore, the proportion of all highest and high needs participants supported in the community with HCBS, as opposed to nursing facilities, was 47%. For the highest needs participants, 42% were in settings other than nursing facilities, maintaining the gains CFC has made in this measure over six years. In addition to coordination efforts in years past, CFC instituted changes designed to improve coordination of services for the moderate needs group as they move between regions of the state.

- *Experiences of Care*: Satisfaction with programs remains uniformly high with 93% of all HCBS respondents being very or somewhat satisfied. For specific CFC programs, all percentages were at least that high, with Personal Care respondents at 99%. For CFC programs, percentages ranged from 93% to 99%. Another experience of care measure involves the extent to which individuals feel that services have helped them remain in their home. While 81% of all HCBS respondents felt that it would be very difficult or difficult to remain in their homes without services, between 68% and 93% of specific CFC programs felt the same way. Virtually all (96%) HCBS participants reported "good" or "excellent" when asked about the "courtesy of others", with 93%+ of CFC respondents reporting the same. Although these above measures were uniformly high, one concern is the decreasing rates of respondents indicating that staff worked with them to resolve problems noted for all four programs. Though very few reported problems, many of the few did not report that staff had worked to resolve the problem

- *Quality of Life:* In 2011, the percentages of CFC respondents who said that the help they received made their lives much better or somewhat better had increased as compared to 2010. In 2011, there were few differences in quality of life/life satisfaction found comparing the CFC programs; there were some differences with Homemaker services scoring lower. These scores had remained mostly stable compared to 2010. There was no difference in scores related to time in with the services, a proxy for time of disability.

- *Impact of Waiting/Applicant List:* Although the high needs applicant list has been active most of the five years, in February 2011 the list was eliminated. In 2011, the moderate needs list was unfrozen and qualified Medicaid Participants received services. In order to better understand the impact of the moderate needs group applicant list, a focus group of case managers was conducted. This applicant list shows a higher level of demand for homemaker services over adult day center. The focus group related how these services could represent community living over homelessness.

- *Budget Neutrality*: DAIL continued to manage CFC spending in a way that stayed within annual appropriations, thus ensuring budget neutrality for the demonstration period.

- *Public Awareness:* Although DAIL has not engaged in a public awareness campaign, some measures have shown that some information is being shared. Current Consumer Survey data highlight that 70% of HCBS respondents have spoken with someone about ways to get help with daily activities and most are satisfied with the information. Other data were not available.

- *Health Outcomes:* Self-reported health, as a measurable and accessible indicator of health outcomes, declined from 51% to 46% responding that health was excellent, very good, or good, compared to others.

Even though consumers are overall very satisfied with the program and ongoing progress continues to be made, there are areas which allow for improvement.

One major recommendation involves the actual evaluation framework. The framework and outcomes should be revisited at this time and revised to ensure that useful data are collected, summarized and presented within outcomes that are important to DAIL and CFC. Specifically, adding survey questions to the Customer survey, accessing existing data sets related to outcomes, collaborating with state staff involved in nursing facilities to determine appropriate measures for that population and exploring partnerships with initiatives such as the Dual Eligibles will allow this evaluation to remain useful and flexible, resulting in findings that provide solid information about progress as well as actionable recommendations. Also, this revision could include the addition of specific evaluation activities related to the moderate needs group to investigate the characteristics of this group and its progress in CFC.

Based on the above findings, the Evaluators encourage DAIL to consider activities within the following outcome areas.

Information and Dissemination: DAIL provides many of its brochures, forms and manuals on-line. In order to proactively increase awareness of its programs and materials, DAIL can conduct a thorough review of its website current content and take steps to continually update and to maintain CFC materials. Adding a question to the annual consumer survey about whether or not people have ever accessed the website would also allow us to measure improvements.

Access: DAIL continues to contend with the issue of streamlining the financial determination process. DAIL can work with its providers to ensure that everyone understands its new initiative, Waiver While Waiting. DAIL should continue to explore how to expand access through increasing numbers of participants who use the newer service options including Flexible Choices, PACE, 24 hour care and paid community spouse. Perhaps additional outreach and awareness of these options is needed. Furthermore, with MFP and its Adult Family Care option, DAIL should continue to explore how to expand this option for CFC as an additional way to improve access.

Experience of Care: DAIL has established that the CFC program will provide quality services which meet the needs of elders and adults with disabilities who need long-term support services. Therefore, as DAIL continues, it is important that all participants report that their problems were resolved or that program staff worked to help them resolve their problems. DAIL should work with the staff at all levels that interact with consumers in the specific programs. As noted in the 2010 and 2011 consumer satisfaction survey, this is currently a small issue. However, if unaddressed, it has the potential to become a larger problem because it can diminish DAIL's quality of customer service. We encourage DAIL to identify specific providers from survey data for individual follow up or additional training.

Effectiveness: Effectiveness includes care coordination. One of the more prominent groups requiring care coordination is individuals with mental illness. With the MOA in place with DMH, this may be the time to look more closely at useful and meaningful collaborations between CFC and DMH. Also, with a revision to

the evaluation plan, a closer focus on the moderate needs group and its characteristics may be useful to determine the utility of this group's inclusion in CFC moving forward.

Quality of Life: A more in-depth understanding of how CFC participants' quality of life changes in CFC while in CFC may be a useful recommendation. The survey currently measures program-level and component-level quality of life. One option may be that building on its tradition of engaging stakeholders, DAIL may want to work with stakeholders to identify one specific quality of life composite and to develop a plan for improvement.

Public Awareness: DAIL is encouraged to review this domain and to determine whether the everyday understanding of the term (developing some type of marketing campaign) truly will aid with the on-going implementation of the CFC program. Research suggests that if DAIL focuses its awareness efforts on a particular segment of the Vermont population, the implementation of a public awareness campaign may be more achievable. Also, as DAIL implements other initiatives such as its Duals project, MFP and the hospice and CFC project, DAIL should explore if there are opportunities to promote awareness of the CFC program.

In this sixth year of the CFC program, DAIL met the needs of those Vermonters who need long-term support services. As with any far-reaching program, there are areas which can be improved. However, with an overwhelmingly high rate of consumer satisfaction, DAIL is well positioned to meet the current and future needs of Vermont's elders and adults with disabilities who use the CFC program.

References

Bruner-Canhoto, L., & Cumings, C. (2011). Vermont Choices for Care Evaluation Years 1 – 5. Disability and Community Services, University of Massachusetts medical School.

Bruner-Canhoto, L., & Cumings, C. (2012). Non-medical Provider Policy Brief. Disability and Community Services, University Of Massachusetts Medical School.

DAIL. (2011). DDAS, Challenges Bi-weekly report. Retrieved from http://dail.vermont.gov/challenges-for-change#documentContent.

DAIL. (2010). Choices for Care 1115 Waiver Renewal Application: 2011-2016. Waterbury, Vermont. Retrieved from http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-default-page#cfc-renewal.

DAIL. (2011). Advisory Board Minutes. March 10, 2011. Provided via email January 2012.

DAIL. (2011) Advisory Board Minutes. April 22, 2011. Provided via email January 2012.

DAIL. (2011) Advisory Board Minutes. May 12, 2011. Provided via email January 2012.

DAIL. (2011) Advisory Board Minutes. July 15, 2011. Provided via email January 2012.

DAIL Business Office. (2012). September 2011 data on CFC Expenditures. Provided through an Email on January 2012.

DAIL. (2012). SAMS data on CFC participant by Level of Care and Setting as of September 2011. Provided via email January 2012.

Edelman, A. (2011). Release of Funds to Serve Some People on the Moderate Needs Wait list. Retrieved from http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-moderate/policies-cfc-moderate-documents/mng-process-memo.

Hill, B. (2011). *Choices for Care Quarterly Data Report* January *2011*. Vermont Department of Disabilities, Aging and Independent Living. Waterbury, Vermont.

Hill, B. (2011). *Choices for Care Quarterly Data Report* March *2011*. Vermont Department of Disabilities, Aging and Independent Living. Waterbury, Vermont.

Hill, B. (2011). Vermont 1115 Demonstration Waiver Semi-annual report: October 2010 – March 2011. Vermont Department of Disabilities, Aging and Independent Living. Waterbury, Vermont.

O'Connor, D., Quach, E., Centerbar, D., & Savageau, J. (2010). 2009 DAIL Consumer Satisfaction. Office of Long-term Support Services, University of Massachusetts Medical School.

Quach, E., Centerbar, D., O'Connor, D. & Savageau, J. (2010). Vermont Choices for Care: Evaluation of Years 1-4. University of Massachusetts Medical School. Worcester, Massachusetts.

Robertson, B., Maurice, J., & Madden, P. (2010). Vermont Long-term Care Consumer Survey. Market Decisions, Maine.

Robertson, B., Maurice, J., & Madden, P. (2011). Vermont Long-term Care Consumer Survey. Market Decisions, Maine.

Wehry, S. (2011). Policy Changes Related to Providing People with Moderate Need Services. Retrieved from http://ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-moderate/policies-cfc-moderate-documents/mng-policy-change-memo.

Contact Information

Laney Bruner-Canhoto
Disability and Community Services
University of Massachusetts Medical School
333 South Street
Shrewsbury, MA 01545

Phone: (508) 856-8439
Email: Laney.Bruner-Canhoto@umassmed.edu

Commonwealth Medicine
UMASS MEDICAL SCHOOL
Applied Knowledge in Public Service