Vermont Extending Home and Community-Based Services
Report and Recommendations

PREPARED FOR THE VERMONT DEPARTMENT OF DISABILITIES, AGING & INDEPENDENT LIVING

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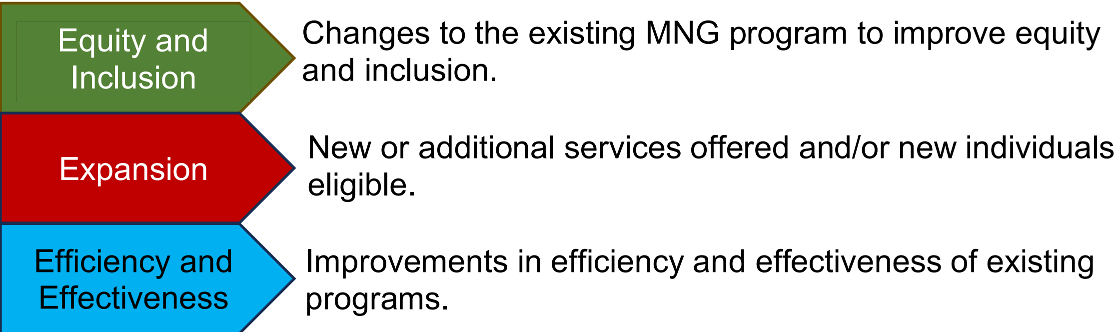
Executive Summary

Recommendation Categories

The recommendations in this report fall into three categories:



Who is Impacted?

The Choices for Care (CFC) program today predominantly serves individuals who are eligible for nursing home level of care, meaning they require extensive assistance with activities of daily living (ADLs).[1] The program also serves some individuals who do not qualify for nursing home level of care but benefit from a package of services to prevent or delay the need for a higher level of care. This second group is called the Moderate Needs Group (MNG). Vermonters served by the MNG program are not guaranteed services today. The table below shows the number of individuals by Choices for Care program population and potential population (at risk) that would be impacted by the recommendations included in this report, including costs per participant per year (PPPY) and total program costs for all participants (Total).

Table 1: Impacts on people and funding.

# people	Choices for Care (CFC)	$ PPPY	$ Total	Description
5,715	High | Highest*	$76,870	$439M	Individuals found to meet the financial and clinical eligibility criteria for nursing home level of care. They require extensive daily supports. They can be served today in nursing homes, other facilities, at home and in their community.
1,095	Moderate (MNG)*	$6,144	$6.7M	Individuals in this group do not meet nursing home level of care criteria to receive services today. The services offered are limited. Services available to this

[1] Choices for Care (High/Highest) provides a package of long-term services and supports to Vermonters who are age 18 years and over and need nursing home level of care. People who need nursing home level of care typically require extensive or total assistance on a daily basis with personal care. Eligible people choose where to receive their services: in their home, in their family's home, an Adult Family Care home, Enhanced Residential Care or nursing facility. People must meet a clinical and financial eligibility for long-term care Medicaid in Vermont (copied on 10.31.2023 from: https://asd.vermont.gov/services/choices-for-care-program)

				group include homemaker, adult day, case management, and flexibility fund. Funding is limited for this group.
500-700†	Moderate (MNG) Waitlist**	TBD†	TBD†	Individuals in this group applied for the MNG program and were put on a waitlist in the order the application was received.
TBD††	At Risk***	TBD††	TBD††	These are individuals who meet specific criteria (to be developed) that place them at risk of needing supports for activities of daily living (ADLs) or instrumental activities of daily living (IADLs) and are financially ineligible for Medicaid.

*Current CFC program participants
**Current MNG waitlist (not receiving MNG services)
***Future program participants
† Estimate of number of individuals on the wait list from the final report of the Task Force on Affordable, Accessible Health Care, page 20. Cost pppy and total is not known today as program design decisions will drive costs.
†† Caseload, cost pppy, and total is not known today as future program design decisions will drive these, today there are no program enrollees nor expenditures for this group.

How To Achieve?

The table below is a visual representation of how the recommendations impact the current Choices for Care program populations and the potential expansion population (at risk).

Table 2. Recommendations and impacted populations by recommendation category.

Recommendations	Moderate (MNG)	MNG Waitlist	At Risk
Flexible funding			
MNG operational changes			
Case Management			
Extend MNG to higher incomes			
Establish new Medicaid eligibility category			
Strengthen Outreach…Referral			
Clarify Dementia Respite Grant requirements			

Legend
Equity and Inclusion
Eligibility Expansion
Services Expansion
Efficiency and Effectiveness

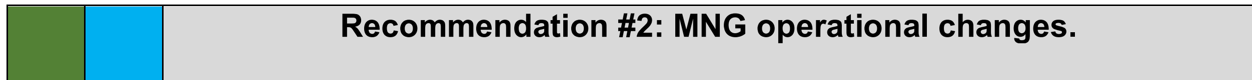
Recommendations

The following high-level overview provides an outline of the recommendations. The full report contains detailed information on each recommendation including workgroup perspectives, consideration of state and national promising practices, and impacts and considerations on people and programs.

Recommendation #1: Prioritize flexible funding.

1. Maximize the flexibility of the limited funds. Flexible funding options support personal choice and preferences, offering participants flexibility in choosing

services and supports that address their unique needs. Flexible funding can also help fill gaps considering the direct service workforce shortage.

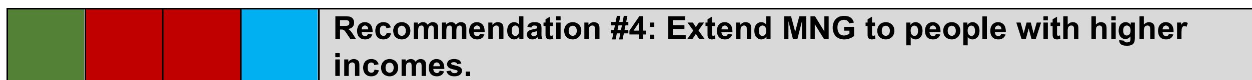


Recommendation #2: MNG operational changes.

1. Establish standard criteria to prioritize individuals on the waitlist for MNG services.
2. Streamline the process for reallocating unspent funds both within regions and statewide.

Recommendation #3: Make case management available as a standalone service.

1. Allow MNG recipients to receive case management services without receiving other services.
2. Create a case management-like service for consumers with lower levels of need.



Recommendation #4: Extend MNG to people with higher incomes.

1. Add training and supports for family caregivers based solely on ADL/IADL/SDOH criteria.
2. Allow buy-in / cost sharing options for Vermonters not income eligible for MNG.
3. Modify MNG financial eligibility to accommodate higher incomes.
4. Provide clearer guidance on existing financial eligibility criteria.

Recommendation #5: Establish a new Medicaid eligibility category.

1. Add a new category for individuals at risk of becoming eligible for MNG.
2. Consider a pilot project to measure the impact of change.

Recommendation #6: Strengthen outreach, awareness, education, and referral.

1. Review and update all public-facing materials containing MNG information.
2. Promote opportunities for shared learning and education on available HCBS services inclusive of key community access points for consumers (e.g., AAAs, VCIL, 211, town clerks and nurses, emergency responders, places of worship, etc.).

Recommendation #7: Clarify Dementia Respite Grant eligibility requirements.

1. Clarify eligibility requirements including all public information to assure program equity across Vermont.
2. Provide opportunity for greater access by modifying requirements for screening for eligibility.

Recommendation Development and Considerations

The recommendations were developed primarily, but not exclusively, from the workgroup discussions. Additional details, including current related policies, recommended policy changes, and policy and fiscal implications are included in the full report. Overarching considerations that apply to the recommendations include:

This work was happening concurrently with other Vermont HCBS stakeholder activities, which should be considered when acting on the recommendations included in this report. Specifically, the **Vermont Complex Care Planning Workgroup, Age Strong VT** (formerly Vermont Action Plan for Aging Well[2]) and the Vermont **HCBS Conflict of Interest project**[3] are important initiatives that may impact the current HCBS system and may alter the appropriateness of recommendations, depending on the outcomes of those initiatives.

Global Commitment to Health Investment dollars may be considered as a source of funding for some recommendations.

Many of these recommendations require resources and staffing capacity to implement, including at DAIL, other state agencies, and in community-based organizations.

Background

In 2021, the Vermont Legislature passed Act No. 74, Sec. E. 126b, creating a Task Force on Affordable, Accessible Health Care to "explore opportunities to make health care more affordable and accessible for Vermont residents and employers". Four Policy Options resulted from that Task Force including Extending Moderate-Needs Supports. The Extending Moderate-Needs-Supports Policy Option from this report was incorporated directly into Act 167, Section 8 and provides a solid foundation from which the VT Extending HCBS Workgroup begins its work. Health System Transformation, LLC (HST) was engaged by the Vermont Department of Disabilities, Aging & Independent Living (DAIL) Adult Services Division through a state procurement process in the Fall of 2022 initiated by DAIL in response to Section 8 of Act 167 (S.285).

Methodology

[2] Age Strong VT (formerly Vermont Action Plan for Aging Well) Advisory Committee 2023 Meeting Agendas, Minutes and Presentations | Disabilities Aging and Independent Living

[3] Vermont HCBS Conflict of Interest Project

While Section 8 of Act 167 identified the primary topics to discuss, HST collaborated with DAIL to identify framing questions for each topic area as well as presentation of state and national evidence-based informed promising programs and practices and state strategies and policies of interest for that specific topic area.

Overwhelmingly, the workgroup cited flexible funding as the most important strategy for extending HCBS to more Vermonters and their caregivers as it provides funds directly to people so they can choose the services they need and want.

Meeting Process

HST facilitated eight monthly meetings from January 2023 through August 2023 in a mostly hybrid format, either in person at an Agency of Human Services (AHS) conference room or via Microsoft Teams web conferencing provided by DAIL. While the meetings were not intended to be a consensus-based process, they were facilitated in a way that was meant to ensure all voices and perspectives were heard and included in the development of themes, and ultimately of recommendations.

Table 1. Meeting Topics and Summarized Discussions Organized by Themes

Theme 1: Services Needed
The workgroup identified numerous factors that impact access to and availability of services: • social determinants of health (SDOH) • geographic variation in services offered • the direct service workforce shortage • Vermont's culture of fierce independence • overarching cultural barriers • affordability • eligibility criteria • rural and urban differences; and • the overall complexity of the HCBS service system, which is compounded by a lack of awareness and education about available options.
Theme 2: Clinical and Financial Eligibility Considerations
Workgroup discussions about financial and clinical eligibility were primarily in the context of the MNG program. Clinical eligibility was generally viewed as already being quite broad. Many workgroup members expressed concerns that the financial criteria for inclusion in MNG is too restrictive. A buy-in option or cost sharing structure for MNG was suggested, as it could help include more people who would otherwise not be financially eligible
Theme 3: Funding Opportunities and Considerations
The workgroup identified both funding and operational challenges with the way that MNG funding is currently managed. Funding challenges are exacerbated by the fact that the MNG program is not an entitlement and therefore is always at risk of being cut. Concerns raised included: How to creatively meet participant needs given the workforce shortage; how to be sure that funds are equitably distributed around the state where they are needed; how to access case management as a stand-alone service if other services are not available; how to increase pay for caregivers; and how to make MNG funding more stable and less subject to discretionary budget adjustments.
Theme 4: Supporting Family Caregivers
The workgroup collectively agreed that family caregivers are overwhelmed, don't have the time, often don't know how to ask for help, don't know what resources are available to help them, and need help navigating the complex system of services to even know what is possible. To address these challenges, the workgroup focused on several promising practices and ideas including suggesting the role of a care or service navigator that could help caregivers as well as the person needing assistance.
Theme 5: Populations

While Vermont is one of the most homogenous states in the nation, Vermonters with limited English proficiency were identified as having access challenges greater than most Vermonters along with people with multiple chronic conditions and disabilities, especially those with a combination of mental and physical health challenges. Reaching out for help or receipt of services is often stigmatized, reinforcing the fierce Vermont "independence mindset". People who are dually eligible for both Medicare and Medicaid are also a population that traditionally has the most complex care needs across physical health, behavioral health, and long-term services and supports (LTSS). It was noted that the one program that did serve the dual eligible population was the Program of All-Inclusive Care for the Elderly (PACE), Vermont, Inc., which closed in 2013. Several workgroup members advocated for revisiting PACE, while acknowledging that if taken up again it would require much further exploration, analysis, and input from diverse stakeholders.

Background

In 2021, the Vermont Legislature passed Act No. 74, Sec. E. 126b, creating a Task Force on Affordable, Accessible Health Care to "explore opportunities to make health care more affordable and accessible for Vermont residents and employers". The Task Force was made up of three members from the House and three from the Senate. Four Policy Options resulted from that Task Force including Extending Moderate-Needs Supports. The key advantage of this option was to increase access to assistance with activities of daily living (ADL) for more Vermonters, estimated at the time to be approximately 500 – 18,000 individuals. Furthermore, such a policy consideration aligned with other options by delaying or eliminating "the need for more intensive levels of support reducing individual and system costs, and supporting "the cost growth benchmark goal of moderating the growth rate."[4] The estimated cost to implement extended supports through a waiver submission and accompanying analytics was estimated to be $200,000, estimated annual ongoing costs ranged from $1.7 million to $33 million, and annual costs avoided per 100 people was estimated to be $11.7 million.

The Task Force provided justification that such an extension of supports is an asset protection strategy that targets a broad middle-class population given that almost three-quarters of people aged 65 and over will require some level of assistance with ADL supports at some point in our lives. Providing a limited package of home-and community-based services (HCBS) to individuals not yet eligible for Medicaid services and that are not typically covered by insurance plans were opined to improve quality of life, promote health and wellbeing, and stave off the need for more intensive long-term services and supports (LTSS). The Extending Moderate-Needs-Supports Policy Option from this report was incorporated directly into Act 167, Section 8 and provides a solid foundation from which the VT Extending HCBS Workgroup begins its work.

Section 8, Options for Extending Moderate Needs Supports, required that "As part of developing the Vermont Action Plan for Aging Well as required by 2020 Acts and Resolves No. 156, Sec. 3, the Department of Disabilities, Aging and Independent Living shall convene a working group comprising representatives of older Vermonters, home-

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[4] Report to the Vermont Legislature, Sec. E.126b(d)(1) of Act 74 of 2021, Health System Transformation, LLC, April 4, 2022.

and community-based service providers, the Office of the Long-Term Care Ombudsman, the Agency of Human Services, and other interested stakeholders to consider extending access to long-term home-and community-based services and supports to a broader cohort of Vermonters who would benefit from them, and their family and prepare a report of recommendations for the legislature by January 15, 2024."

Additionally, as part of larger healthcare reform and transformation in Vermont, and if so directed by the General Assembly, DAIL is to "collaborate with others in the Agency of Human Services as needed in order to incorporate the working group's recommendations on extending access to long-term home-and community-based services and supports as an amendment to the Global Commitment to Health Section 1115 demonstration in effect in 2024 or into the Agency's proposal to and negotiations with the Centers for Medicare and Medicaid Services (CMS) for the iteration of Vermont's Global Commitment to Health Section 1115 demonstration that will take effect following the expiration of the demonstration currently under negotiation."

Health System Transformation, LLC (HST) was engaged by the Vermont Department of Disabilities, Aging & Independent Living (DAIL) Adult Services Division through a state procurement process in the Fall of 2022. A Request for Proposal (RFP) was issued by DAIL in response to Section 8 of Act 167 (S.285), An act related to health care reform initiatives, data collection, and access to home-and community-based services, signed by the Governor on June 1, 2022.

VT Extending HCBS Workgroup

Creation

HST prefaced the workgroup creation by drafting a workgroup charter[5] outlining the project's vision, workgroup purpose, key assumptions, meeting ground rules, and topic overview to assist in identifying potential membership. The charter was shared with DAIL and guided DAIL and HST's series of planning meetings for workgroup creation including the invitation process and meeting format. DAIL approval was required for all decisions.

While Section 8 of Act 167 identified the primary topics to discuss, as outlined in **Appendix C, Table 1**, HST collaborated with DAIL to identify framing questions for each topic area as well as presentation of state and national evidence-based informed promising programs and practices and state strategies and policies of interest for that specific topic area.

Meeting Process

HST facilitated eight monthly meetings from January 2023 through August 2023 in a mostly hybrid format, meaning members were invited to attend in person at an Agency of Human Services (AHS) conference room at the Waterbury State Office Complex or

[5] Please see Appendix B.

could participate via Microsoft Teams web conferencing provided by DAIL (there were two virtual-only meetings when no members opted to attend in person). HST developed agendas and PowerPoint slide decks to guide the conversations and provided meeting facilitation and note taking. Slide decks were approved by DAIL prior to being delivered to the workgroup members in advance of the monthly meetings. The online 'Mentimeter.com' polling tool was used as part of the meeting facilitation to help members summarize and respond to targeted questions and to encourage engagement from those who tend to be more silent during the discussion or prefer to share their input anonymously. While the meetings were not intended to be a consensus-based process, they were facilitated in a way that was meant to ensure all voices and perspectives were heard and included in the development of themes and ultimately of recommendations.

Topics Discussed

Table 1 in Appendix C describes the monthly meeting topics as provided by Act 167 along with agreed upon questions used to facilitate the discussion.

Research

Each month HST researched and presented to DAIL potential strategies, programs, and practices being considered or adopted by other states that supported the topic for discussion. Vermont-specific policies, programs, activity, and data were also included if relevant to the topic. The purpose of the research was to broaden the workgroup's understanding of how other states approached or are addressing similar challenges and opportunities to stimulate discussion and ideas as 'food for thought'. After discussion, the workgroup shared feedback on state strategies, programs, and practices and whether such approaches might be a good fit for Vermont.

Additional Meeting Preparation

In addition to the monthly meetings, HST held separate pre-meeting conversations with a small group of members (generally no more than three) who had a particular interest, expertise and experience with a given monthly topic. These meetings provided an opportunity to spend more time reviewing the topic and purpose, build out the framing questions, and generate ideas for how to approach the topic and stimulate workgroup discussion. It also allowed time for additional research if needed prior to the full workgroup meeting. For some topics, HST also conducted meetings with subject matter experts to gather relevant information that was shared with the workgroup.

Planning Meetings

Collaboration meetings between HST and DAIL followed an agreed upon monthly cadence. For the first workgroup meeting DAIL and HST met to plan for and agree upon the agenda, research materials, framing questions, and slide deck content. For all other meetings DAIL and HST met shortly after each meeting to debrief on the prior month's meeting and plan the upcoming meeting. Conversations were very collaborative, with all parties contributing ideas and information to prepare for and conduct each monthly workgroup meeting. Current activities and related initiatives and possible impacts were identified and discussed and included as part of the workgroup's discussions.

Summary of Workgroup Discussions by Key Themes

HST condensed the meeting topics into key themes for this report. The themes assisted in developing the recommendations, particularly those that were reinforced repeatedly across all eight meetings regardless of the topic for discussion. A recurring issue, which is not noted as a separate 'theme' but is added as a recommendation, has to do with either a lack of information or misunderstanding of available information. There were numerous examples of workgroup members' understanding of policies and processes that were inconsistent with formal State policies; thus, a recommendation to address improvements in outreach, education, and awareness was added.

The workgroup's input was the primary source used to develop the recommendations included in the report, with DAIL input, subject matter expert interviews, and research into other states' innovations also considered. The process was one of listening intently to all parties and distilling the themes into the recommendations contained in this report. This was not a consensus-based process; however, the report was vetted with all workgroup members and their comments are included in the attached letters[6].

Table 2 lists the key themes from the workgroup's discussions and is followed by a summary of workgroup input and the report recommendations. Full meeting notes are provided in Appendix C.

Table 2: Workgroup Discussion Themes

Theme 1	Services Needed
Theme 2	Clinical and Financial Eligibility Considerations
Theme 3	Funding Opportunities and Considerations
Theme 4	Supporting Family Caregivers
Theme 5	Populations

*The workgroup consistently identified **flexible funds** as the **most important strategy** for extending HCBS supports to more Vermonters and their caregivers.*

Theme 1: Services Needed

The workgroup identified numerous factors that impact access to and availability of services, including social determinants of health (SDOH); geographic variation in services offered; the direct service workforce shortage; Vermont's culture of fierce independence; overarching cultural barriers; affordability; eligibility criteria; rural and urban differences; and the overall complexity of the HCBS service system. **Overwhelmingly, the workgroup cited flexible funding as the number one priority for overcoming these factors as it provides funds directly to people so they can choose the**

[6] Please see Appendix F.

services they need and want. Participants cited numerous benefits of prioritizing the use of flexible funds including helping to fill the service gaps that exist due to the workforce shortage (e.g., purchasing personal emergency response systems), reducing the overhead to agencies who are currenting receiving and distributing the funding, and providing individuals and families more choice in services needed including hiring of their own caregivers. While flexible funding is a very important strategy, agencies noted that expanding the use of flexible funding will not eliminate the workforce shortage that impacts their ability to hire and maintain enough staff to address the needs of current program participants.

Services Needed but Difficult to Access

- Transportation
- Home modifications
- Nutrition services addressing special dietary needs including medical diets.
- Medication management supports (e.g., pre-filled boxes or reminder calls for taking medications)
- Broadband and internet connectivity
- Housing and housing retention services
- Care navigation and supports for people with executive-functioning challenges (e.g., people with dementia or brain injuries)
- American Sign Language (ASL) interpreters or other language interpreters for Vermonters with no or limited English proficiency.
- Alternative sources for homemaker and personal care that can offset the workforce shortage (e.g., remote monitoring systems or supportive technologies)

Workgroup members shared numerous services that Vermonters need but are often not able to access fully. Agency leadership in the group (e.g., Area Agencies on Aging (AAAs), Adult Day Services (ADS), Home Health Agencies (HHAs)) expressed frustration at not being able to serve more people with direct care supports due to workforce shortages. Linked to that are low wages and reimbursement that is insufficient to keep up with demand. While there were frustrations and difficulties expressed, the workgroup agreed that there needs to be a focus on creativity and flexibility to recast historical ways of delivering services.

Using flexible funds, agencies with staffing shortages have been able to assist MNG participants to hire people close to them as caregivers. Technology such as personal emergency response systems (PERS) give some relief, increasing the hours individuals can be away from their designated caregivers. Home modifications can allow people to continue to live in their homes. Services such as reminder calls for taking medications can reduce the need for in person home visits. Adult Day can provide important stimulation to combat loneliness while allowing caregivers to go to work, and access to technology can allow people living in more isolated situations to be connected. While different members of the workgroup had varying ideas on what types

of services were needed most, there was resounding agreement that expanding access to flexible funding options is a way to potentially address many of the identified needs.

Theme 2: Clinical and Financial Eligibility Considerations

Workgroup discussions about financial and clinical eligibility were primarily discussed in the context of the MNG program.
Clinical eligibility[7] was generally viewed as already being quite broad with some members saying it is so broad that it would be difficult to find someone that is not clinically eligible. The exceptions to this are some people with early onset Alzheimer's or dementia, and people with brain injuries. Some members feel that executive functioning challenges are not adequately assessed and while the assessment tool should capture those diagnoses, often they are not obvious enough to be clearly recognized by assessors using the current clinical eligibility criteria. Self-neglect populations of all ages were also mentioned. While already broad in nature, the workgroup felt there are some criteria that are currently missing: items addressing SDOH, unmet needs, social isolation, consideration of instrumental activities of daily living (IADL) needs, consideration of caregiver needs and capacity, assessing for executive functioning capabilities and challenges, and mental health diagnosis and the impact on daily living.

Because the current clinical eligibility is so broad, it could be contributing to the long MNG waitlists. The workgroup acknowledged that they know little about those on the MNG waitlist. Some agencies conduct a partial or complete ILA with applicants, while others shared that even doing a screening is too laborious, especially with a lack of workforce and because the screening and assessment for eligibility is not reimbursed. This led to a discussion about prioritization not only of the MNG waitlist, but also for MNG services overall. Rather than serve people on a first-come, first-served basis, which is the current practice, the workgroup discussed whether there should be a statewide methodology for prioritizing the assessment process so that those individuals in greatest need get served first. The workgroup noted that such a step would require discussions as to what defines "in greatest need", which the workgroup did discuss generally.

In July 2023 there were 771 individuals statewide on the waitlist for MNG homemaker services, with over 50% already meeting Medicaid financial eligibility. What is not known is how many of these individuals would meet clinical eligibility. Two AAAs shared with the workgroup the prioritization criteria they are either currently using or are planning to use. It is not yet known how successful these criteria are or will be in serving those in greatest need. Should prioritization be considered statewide, the workgroup noted that there first needs to be revisions to the ILA or whatever tool that might be used for screening to include the criteria described above. Identification and statewide adoption of the actual prioritization criteria is also necessary. Some members shared ideas including frequent primary care practice (PCP) visits, emergency department (ED)

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[7] Choices for Care Moderate Needs Group Program Manual

utilization, availability of informal supports or caregivers, fall frequency, food insecurity, polypharmacy, and use of adaptive equipment among other factors. As part of the prioritization discussion, it was shared that the MNG program will see a change in eligibility in 2025, removing the need to have a chronic condition that requires monthly monitoring and substituting with a broader requirement for a person's health and welfare to be at imminent risk without services. It was suggested that this be taken into consideration alongside any discussions of prioritization criteria or modifications to any screening or assessment tools that assess clinical eligibility.

MNG Financial Eligibility Criteria

- Adjusted monthly income <300% SSI for one person (or couple) in the community after deducting recurring monthly expenses.
- Monthly expenses include prescriptions, medications, physician and hospital bills, health insurance premiums and co-pays, medical equipment and supplies, and other out of pocket medical expenses.
- A $10,000 disregard or "asset adjustment" is applied to all "liquid" assets that are easily convertible into cash (e.g., cash, savings, checking, CD's, money market, stocks/bonds, etc.)

Financial eligibility[8] was discussed at length, with many workgroup members expressing concerns that the financial criteria for inclusion in MNG is too restrictive. The current adjusted income limit was seen as too low (set at 300% of the monthly SSI limit which is currently $2,898 /individual and $4,409/couple[9][10]), and the criteria does not consider multi-generational household factors that may need extra considerations including disregards for housing costs and retirement savings for younger adults who may have children or a spouse to consider. The resource/asset cap was seen as too low and exclusions too narrow, particularly for the younger population with disabilities and for people who may have working spouses who are also caregivers. It was suggested that the financial needs of the caregiver should be considered in addition to the person applying for services and needing care. Preserving housing is extremely important, and it was noted that incomes may appear higher for homeowners, but housing costs and maintenance reduce funds available to help purchase support services.

A buy-in option or cost sharing structure for MNG was suggested, as it could help include more people who would otherwise not be financially eligible. One member noted that MNG prioritizes Medicaid beneficiaries over Vermonters with just Medicare or other insurance, which was seen as limiting and not necessarily serving individuals with higher needs. Many of these individuals not yet financially eligible are still very low-

[8] Moderate Needs Group Program Operations Manual, p. 7
[9] EN-05-11128 - Supplemental Security Income (SSI) in Vermont_(January 2023) (ssa.gov)
[10] CFC 902 Moderate Needs Financial Eligibility Worksheet.xls

income and unable to pay for services out of pocket. Often these are services that are also not paid for or offered by other insurance plans.

While outside of the MNG program, the workgroup shared that the dementia respite grants also have limited eligibility criteria both due to the requirement of having an actual diagnosis of dementia as well as the financial eligibility requirement that impacts family caregivers. It was suggested that the requirement for an actual doctor's diagnosis of dementia be reconsidered as well as removal of the financial eligibility criteria due to the known financial impact that caregiving has on family caregivers. (Note: Later research revealed that a formal diagnosis by a physician is not required, and so the recommendations are focused on clarifying eligibility criteria and allowing for trained assessors to screen for dementia using an evidence-based tool.)

Theme 3: Funding Opportunities and Considerations

The issue of funding extended supports is challenging and the idea of extending supports to additional Vermonters and their family caregivers when there are already challenges in serving current MNG participants was a hard conversation for the workgroup to have. This topic was compounded by the existence of a long standing MNG waitlist. The workgroup asked why it should consider extending HCBS to even more Vermonters and their family caregivers when people on the waitlist are not even being served.

The workgroup identified both funding and operational challenges with the way that MNG funding is currently managed. Funding challenges are exacerbated by the fact that the MNG program is not an entitlement and therefore is always at risk of being cut. It is also a capped program, which is different than the rest of the Choices for Care program, which is open-ended when it comes to how agencies manage it. The funding challenges are multidimensional, and, as the workgroup could attest, often driven by operational policies that haven't been updated in some time.

Operational challenges centered around management of funds including the process of transferring funds from one agency to another and the length of time it takes to make any transfers as well as the actual timing in terms of when it occurs in the fiscal year. While transfers occur today, it is not uniform across the state and currently there is no formal written policy guiding transfers or requests for transfers. This process ends up leaving funds on the table that otherwise could be used to close gaps in need. The MNG program budget was recently cut during the annual budget process because there were dollars allocated that were not used. While dollars were available but not used, there were many Vermonters still on the waiting list because their requested services were not available. Therefore, one workgroup member aptly asked the question: "Is the issue not enough funding or not enough staff?"

Related issues that came up included: How to creatively meet participant needs given the workforce shortage; how to be sure that funds are equitably distributed around the state where they are needed; how to access case management as a stand-alone

service if other services are not available; how to increase pay for caregivers; and how to make MNG funding more stable and less subject to discretionary budget cuts.

Solutions, or areas to explore for further consideration include:

- Freeing up more dollars to be used flexibly to creatively meet participant needs. Some agencies have made greater use of flexible funding and found it to be a way to get some, if not all, of a person's needs met when traditional agency-sponsored services were in short supply. Along those lines, one workgroup member suggested giving money directly to people, like 3SquaresVT, allowing consumers to purchase what they need almost prospectively.
- Developing a methodology for understanding the needs of individuals on the MNG waitlist. The current system lacks a unified statewide process for tracking and prioritizing. Prioritizing the waitlist could move dollars to people most in need.
- Reducing the administrative difficulty that currently exists when agencies attempt to transfer funds to higher need areas if funds are not used as well as understanding and addressing issues that affect agencies' willingness or resistance to making those transfers.
- Providing some type of case management-like or related service such as system or service navigation. Consideration of offering a case management only service option was also seen to be a significant need that is currently not available as a Moderate Needs Group (MNG) stand-alone service. Case management-like or similar navigation supports can help people in need develop a plan, learn about options, and access resources that may or may not be funded by MNG. The Brain Injury Alliance noted that many of their clients need support with paperwork and navigating the system, as do individuals with early-onset Alzheimer's.
- Developing a strategy for determining rates of direct care providers and appropriate increases in rates, which could help stabilize agency budgets and facilitate workforce recruitment and retention.
- Consider a reduction in the number of entities that manage funding to increase administrative efficiencies such as setting up 'pass through' organizations rather than holders of funding.

Because the MNG program has never been deemed an entitlement, it is less stable financially. HST shared information about the Washington Tailored Supports for Older Adults program[11] that created a new eligibility category and benefit package for people aged 55 or older who are "at risk" of needing LTSS in the future and who do not currently meet Medicaid financial eligibility criteria.

Theme 4: Supporting Family Caregivers

Perhaps not surprisingly, there was full consensus on the importance of family caregivers and the need to support them. The workgroup acknowledged cultural shifts that have taken place over the years, including a growing migrant population and new

[11] Tailored supports for older adults (TSOA) | Washington State Health Care Authority

Americans who are without their support systems back home. It was stated that the predominant American culture doesn't sufficiently value and respect the role of caring for older family members.

The workgroup collectively echoed the voices of workgroup members who are either caregivers themselves or are being supported by a family caregiver: family caregivers are overwhelmed, don't have the time, often don't know how to ask for help, don't know what resources are available to help them, and need help navigating the complex system of services to even know what is possible. When caregivers do reach out for help, workgroup members shared that many agencies and organizations lack the knowledge themselves about what programs and services are available to help caregivers and their loved ones, thus compounding the knowledge gap. Often in these circumstances caregivers just give up. If they can find services that may meet their needs, there is too much paperwork to get through and often it is duplicative, asking the same questions.

Due to the lack of awareness of what is currently out there to support family caregivers, they often are at huge risk of burnout including emotional and physical impacts, and financial devastation including bankruptcy and falling into poverty. It was noted that many family caregivers still work, compounding the challenges of caring for their loved ones as well as earning income to continue to support their families. Existing support systems such as caregiver support programs don't meet the needs of all family caregivers, particularly working caregivers.

Current gaps exist in assessments used to gather information about a person's needs and the caregiver's needs. This is especially apparent for people with executive functioning or cognitive challenges. It is hard to make recommendations or referrals for services, or to even develop a person-centered service plan, if the person's functional needs are not clearly defined or understood.

To address these challenges, the workgroup focused on several promising practices and ideas including suggesting the role of a care or service navigator that could help caregivers as well as the person needing assistance. While the use of technology to support caregivers was raised by some workgroup members as well as shared as examples across states, there were concerns expressed by some that technology should not replace the human connection and should be an added benefit versus a replacement (e.g., some types of artificial intelligence). Some members expressed concerns that older adults may be less able or willing to embrace technological supports, and younger persons with disabilities may fear that technology will take away self-direction and independent decision-making. HST shared experiences from other states and state practices that indicate with appropriate training and support both older adults and people with disabilities are open to using technology to help augment and maintain their independence. Other ideas included:

- Stipends provided directly to caregivers for work they are already doing

- Flexible funding to pay for respite services (e.g., in-home care, adult day, out of home respite, etc.)
- A dedicated support person who can listen and create a relationship with the caregiver to understand and respond to their unique needs.
- Tax credits
- Unemployment benefits for people that must leave a job to become caregivers
- Paid family leave
- A formal network of paid peer supporters with lived experience as a caregiver
- Expand the use of tools like Trualta[12] and TCARE[13]
- Explore other technologies that can support and reduce burden on caregivers
- Use of many different channels to get the message out about caregiver supports such as PCPs, town clerks, ministers, etc. Promoting services is important to combat stigma and encourage caregivers to seek help early.

Agency workgroup members, primarily AAAs, shared their experiences with current caregiver support program products such as TCare and Trualta. Many AAAs currently use these services and reported satisfaction not only by staff but also the caregivers and people benefiting from their offerings and wondered whether these products could be expanded more broadly. It was noted that adult day services are an important and diverse support not only for the person attending, but also for the family caregiver and entire family, providing much needed respite and helping the entire family system. The workgroup expressed that there already exists information, services and supports to help family caregivers but that more effort needs to be placed on making it more readily known, understood, and easy to access. Existing channels include women circles and local connections via trusted channels such as town clerks, town nurses, and libraries.

One workgroup member provided an overview of the Vermont Dementia Family Caregiver Center and a new volunteer mentor pilot program that hopes to go statewide. There is also caregiver peer to peer support groups currently underway.

Theme 5: Populations

Vermonters in greatest need of extended supports

The workgroup identified those populations it considers the most disenfranchised or who are experiencing the greatest difficulty in accessing services, and therefore might be "in greatest need" of extended supports. The list includes, but is not limited to:

- People impacted by COVID-19 and the resulting long-term chronic conditions
- Immigrants and migrant populations
- People with executive functioning challenges whose needs and functional limitations are not understood as they often "fly under the radar" of most healthcare providers
- People who are about to be homeless or are being transitioned to or released back to the community without adequate supports, and the unhoused

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[12] Trualta - Education and Support for Every Caregiver
[13] TCARE | Tailored support for family caregivers.

- People under the age of 60 with brain injuries, or younger adults with dementia who often feel left out of services due to their cognitive challenges and injuries. They are often bounced around to different agencies when they already experience challenges navigating the system
- People who traditionally have been in marginalized groups
- People who do not have support from family or friends and have health needs but are not connected to traditional programming
- People who live alone or are experiencing social isolation/loneliness
- People with limited English proficiency
- People with multiple chronic conditions and disabilities, especially those with a combination of mental and physical health challenges.

It was noted that for many people, experiencing social isolation often causes them to remain disconnected from needed services and workgroup members said that the COVID-19 public health emergency made that abundantly clear. While Vermont is one of the most homogenous states in the nation, Vermonters with limited English proficiency were identified as having access challenges greater than most Vermonters along with people with multiple chronic conditions and disabilities, especially those with a combination of mental and physical health challenges. Reaching out for help or receipt of services is often stigmatized, reinforcing the fierce Vermont “independence mindset”. There is also a misunderstanding about the HCBS system of services that results in people harboring fears that they will lose their property or their life’s savings if they apply for or become eligible for services they need and want.

Along with specific population characteristics are the surrounding regional and cultural factors such as urban/rural differences, cultural values of ‘fierce independence’, workforce pressures that vary regionally along with service offerings and availability. The workgroup noted a distinct urban/rural distinction when it comes to services.

The workgroup acknowledged that many of these populations are turned away from multiple organizations, live in poverty, don’t financially qualify for Medicaid but can't pay for services, have unmet needs (including unmet ADL/IADL needs, food security, stable housing, etc.), caregivers who need a break, and are not eligible for other programs or the programs do not adequately address their needs.

Identifying Vermonters in greatest need

The workgroup discussed how to best identify Vermonters in greatest need that could benefit from extended HCBS supports. They noted that finding people in greatest need who are not already being identified and served with existing programs can be very challenging. Workgroup members felt that efforts should start with primary care practices, community health teams, Supports and Services at Home (SASH), and other providers who are the first touchpoints for populations. These are often very local, and regionally and culturally driven including town clerks and nurses, churches and other religious congregations, emergency medical technicians (EMTs), home-delivered meals, other community health workers, and transportation drivers, among others. Use

of social media campaigns, TV, Facebook, and other social media channels were mentioned.

Tapping into and maximizing the power of existing data sources such as Vermont Information Technology Leaders (VITL) were seen to be only as effective as the data entered and the criteria used with which to identify people in need. A meeting with VITL acknowledged their limitations as well as potential capabilities. While many providers share data, and many Vermonters are included in their data set, it is by far not universal. There is potential to utilize HIPAA-compliant and/or aggregate data from HCBS providers to develop queries that could identify trends in population utilization of services (e.g., hospital admissions, emergency departments (ED), and nursing facilities) to provide a deeper and more comprehensive picture of populations at greatest risk, as well as identifying clinical factors that drive utilization and characteristics of people in need. It was noted that much work, including adding the use of artificial intelligence (AI), could be done to improve capabilities. VITL is interested and open to discussing these types of enhancements if funding sources make it possible.

Another data source is the stratified data that OneCareVT supplies to enrolled providers and the Blueprint for Health to meet care coordination needs of their attributed members. The Blueprint's Community Health Team professionals then reach out to provide assessment, referral to services, and other care coordination functions. OneCareVT is currently developing systems to assess their members for SDOH, which will be an additional source of information to identify Vermonters who need extended supports. They are adopting CMS-developed screening tools that will standardize the collection of data across key risk areas such as housing instability, transportation problems, food insecurity, functional abilities, and utility needs. It was noted by workgroup members that sensitivity needs to be considered when asking these questions as part of standard SDOH screenings as they are not asked of all populations in an equitable manner. It was suggested that where and how these questions are asked be considered.

Other sources that aggregate useful data that can be used to identify what people's needs are as well as their characteristics include 211, the AAAs and the data captured via their Senior Helpline, and other agency information and assistance data that is tracked,

People who are dually eligible for both Medicare and Medicaid area population traditionally have the most complex care needs across physical health, behavioral health, and LTSS. Vermont does not currently offer "dual eligible" health plans, often referred to as Dual Eligible Special Needs Plans (DSNPs). It was noted that the one program that did serve the dual eligible population was the Program of All-Inclusive Care for the Elderly (PACE) Vermont, Inc., which closed in 2013. PACE Vermont was seen as a very a good option for serving dually eligible beneficiaries, but after being in place for about four years it stopped serving Vermonters for several reasons, including financial challenges, staffing, and unexpected infrastructure costs. Several workgroup members advocated for revisiting PACE, while acknowledging that if taken up again it

would require much further exploration, analysis, and input from diverse stakeholders. The Medicare Advantage plan, BlueAdvantage collaboration with SASH was reported to be going well for the 100+ people served. It was shared that they are interested in building upon this initial success and serving more Vermonters.

Recommendations

The recommendations described below were developed primarily, but not exclusively, from the workgroup discussions. Overarching considerations that apply to most all recommendations include:

1. This work was happening concurrently with other Vermont HCBS stakeholder activities, which should be considered when taking action on the recommendations included in this report. Specifically, the Vermont Complex Care Planning Workgroup, Age Strong VT[14] (formerly Vermont Action Plan for Aging Well) and the Vermont HCBS Conflict of Interest project[15] are important initiatives that may impact the current HCBS system and may alter the appropriateness of recommendations, depending on the outcomes of those initiatives.
2. Global Commitment to Health Investment dollars may be considered as a source of funding for some recommendations.
3. Many of these recommendations face the challenge of requiring significant resources and staffing capacity to implement them, including at DAIL and other state agencies, as well as community-based agencies.

Recommendation #1: Prioritize flexible funding

Opportunities

Flexible funding options support personal choice and preferences, offering participants flexibility in choosing services and supports that address their unique needs. Flexible funding can also help fill gaps considering the direct service workforce shortage. The workgroup shared many different needs expressed by Vermonters over the years, such as home modifications, medication management, PERS, nutrition services, ASL interpretation, transportation, broadband access, alternative sources of homemaker and personal care services (because of workforce shortages), and many more.

Challenges

- Medicaid funding constraints include limitations related to the annual legislative appropriations process, utilization management, and federal 1115 Waiver terms and conditions.
- The development of rules and regulations to assure equity across a program that is as flexible as possible for individuals will require some time, a commitment to transparency, and the ability to allow for trial and error. This has proven to be very challenging for public programs to achieve at scale.

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[14] Age Strong VT (formerly Vermont Action Plan for Aging Well) Advisory Committee 2023 Meeting Agendas, Minutes and Presentations | Disabilities Aging and Independent Living
[15] Vermont HCBS

Current Policies

A small amount of flexible funds is available through a MNG participant's chosen certified case management agency to pay for services that "contribute to the prevention, delay, or reduction of harm or hospital, nursing home, or other institutional care".[16] In addition to hiring an attendant, flexible funding may be used to purchase goods and services such as PERS, assistive devices, home modifications, personal care, among others. However, flexible funding is limited by available funds.

Recommended Policies

1a. Designate an amount, such as the average spending per MNG participant at current budget levels and inclusive of funds allocated for homemaker services, to be available as flexible funds for MNG participants across all categories of MNG services.
1b. Develop a menu of allowable options for flexible funding including goods and services.
1c. Provide MNG participants with case management, or a case management-like service for those with less complex needs, to facilitate use of flexible funds.
1d. Develop guidance on how to access and utilize allowable goods and services for which flexible funding can be used. Consider using the Vermont Veterans Independence Program guidelines and manual as a place to start.

Policy and Fiscal Requirements and Implications

With more flexibility in how funds are spent, including freeing up funds allocated for homemaker services, more dollars are likely to be used and not 'left on the table'. A transition plan would be needed to ensure current MNG participants do not experience a reduction in their homemaker or adult day services.

National and Evidence-Based Findings and Considerations

Massachusetts Flexible Funding Supports provide Tenancy Preservation and Nutrition Sustaining Supports; Oregon Project Independence offers a list of services for which funds can be expended. Information about both programs is found in **Appendix E.**

Recommendation #2: Implement MNG program operational changes
2a. Prioritize all eligible MNG applicants when funds are limited.
2b. Update or change budget allocation and re-allocation procedures.

Opportunities

2a. Prioritize all eligible MNG applications when funds are limited.

- While it is likely that these funding allocations will be impacted by decisions arising from current conversations regarding Conflict-free Case Management, if funds continue to be distributed by regional providers and waitlists are managed at the local level as they are now, DAIL can create a more equitable process for

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[16] MNG Program Manual, Section IV, Flexible Funding

accessing MNG services by establishing prioritization criteria for eligible applicants on the MNG waitlist when funds are limited.

- Prioritization criteria would include revising the ILA to add key SDOH factors and other items recommended by the workgroup. Assessors would be fully trained to ensure practice is consistent throughout the state. By adding key SDOH and other questions, local providers can prioritize individuals on the waitlist and support the ability to reallocate funds to regions where they are needed most.

2b. Update or change budget allocation and re-allocation procedures.

- Creating a streamlined and efficient process for re-allocating unspent funds will assure that more Vermonters receive services that they need and that no funds are left unspent and are at risk for legislative action.

Challenges

- Coming to agreement on what questions to add to the ILA and how the responses impact an individual's relative needs assessment.
- Developing an equitable and agreed upon system for the reallocation of unspent funds.
- Balancing the preservation of resources for individuals to meet their individual service plan needs against the transfer of unspent allocations to other individuals with unmet needs.

Current Policies

Current clinical eligibility

A. Individuals shall receive eligibility screening by a case manager as the initial step in eligibility determination for the Moderate Needs Group. Individuals who meet any of the following clinical eligibility criteria, as determined by the Department, shall be clinically eligible for the Moderate Needs Group:

1. Individuals who require supervision or any physical assistance three (3) or more times in seven (7) days with any single ADL or IADL, or any combination of ADLs and IADLs.
2. Individuals who have impaired judgment or decision-making skills that require general supervision on a daily basis.
3. Individuals who require at least monthly monitoring for a chronic health condition.
4. Individuals whose health condition shall worsen if services are not provided or if services are discontinued.

Current waitlist management

- The waitlist is currently managed on a first-come, first-served basis by local MNG agencies. There is a lack of consistent standards and criteria for the waitlists with some agencies conducting screenings and assessments and others not.

Recommended Policies

2a. Develop prioritization criteria for MNG applicants that will be used when funds are limited.

1. Develop additional eligibility questions that provide information needed for prioritization.

a. Add questions to the current ILA or screening and assessment tools that address the following:
    - SDOH such as food security, transportation, housing stability.
    - Incorporate questions that address executive functioning.
    - Add questions that address caregiver needs and risk.
    - Consider questions piloted by Northeast Kingdom Council on Aging (NEKCOA) and AgeWell (e.g., unmet needs, social isolation, IADL needs, ED use, fall risk, hospital utilization, availability of informal supports/caregivers, etc.).
    - Consider appropriate questions that address mental health needs and diagnoses/impact on functioning.
    - Add questions for self-neglect.

b. Adopt a conflict-free case management approach[17] to completing the assessment for clinical eligibility, moving away from existing case management agencies to DAIL or other non-vested party.

c. Build in payment for conducting screening of applicants on waitlist.

d. Explore use of VITL and OneCareVT data sources to assist in identifying people in greatest need of services and supports including OneCareVT adoption of CMS Health Related Social Needs (HRSN) screening tool.

e. Educate a broader group of local touchpoints about the MNG program as well as any other expansions to maximize awareness and ability to support Vermonters who seek out help from locally known entities such as primary care providers, town clerks, town nurses, community health teams, Racial Justice Alliance, Migration Justice Alliance, churches, temples, and other religious institutions, etc. and provide MNG program materials to all as well.

2b. Update or change budget allocation and re-allocation procedures.

1. Establish budget allocation procedures between agencies within a region or across regions of the state.
    a. Establish routine procedures for allocation of funds to individuals and transfers of unused funds.
    b. Consider a base allocation for each region based on prior year's spending, with the balance of all funding pooled for re-allocation as needed.
    c. Create tracking mechanisms that allow for discrete services as well as goods and services to be tracked and aggregated by region across care plans. This will allow for more accurate budgeting and expense tracking.
    d. Aggregate budgets and expense tracking at the regional level across the MNG program.
    e. Create a transfer protocol that is transparent and developed using a stakeholder process.
    f. Include a state level allocation that DAIL can use to fill gaps where needed.
    g. Remove administrative barriers to transferring funds.
    h. Allow for transferring funds to higher need areas if funds are not used.

[17] VT HCBS-COI Options

i. Centralize operations and have fewer entities manage funds including consideration of "pass through" organizations rather than them being the holders of the funds.
j. Suggest that the upcoming IT procurement allow for a real-time, transparent connection between budget planning and claiming.

Policy and Fiscal Requirements and Implications

Requires updates to MNG policies and procedures.

National and Evidence-Based Findings and Considerations

2a. Some states prioritize individuals based on age, diagnosis, or situational factors. Some states may base priority on functional assessments or criticality, such as loss of a primary caregiver, loss of home, or risk of institutionalization. States may also use screening tools.[18]

Recommendation #3: De-couple case management from other MNG services

Opportunities

Providing case management as a stand-alone service will allow many people to begin being served or remain a MNG participant when another service isn't available because of workforce shortages or because another service is not needed at the time.

Challenges

Changes to MNG eligibility will be needed, likely requiring federal approval in the form of an 1115 Waiver amendment. Increased funding will be necessary to support increased caseloads.

Current Policies

Per the MNG Program Operational Manual, Case Management alone does not qualify someone for MNG. Each MNG participant must receive either Homemaker or Adult Day.[19]

Recommended Policies

3a. Allow MNG participants to receive case management services in the absence of receiving other MNG services – this could be a case management-like or care navigation service that would benefit not only the person needing services but family caregivers as well.

3b. Revisit and redefine or modify approved Case Management Services that address individuals who need some form of service coordination or system navigation rather than more intensive/clinical case management.

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[18] State-Management-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf (macpac.gov)
[19] MNG Program Operations Manual

3c. Consider creation of a new category of case management -like service such as care navigation or build upon Options Counseling services currently offered through the AAAs by expanding the organizations that can provide Options Counseling.
3d. Consider exploring Medicaid claiming for the delivery of Options Counseling.

Policy and Fiscal Requirements and Implications

With more flexibility in how funds are spent, more dollars are likely to be used and not 'left on the table'. There is a question of whether recent budget cuts be reinstated?

National and Evidence-Based Findings and Considerations

Oregon Project Independence offers a list of services for which funds can be expended, including service coordination. See **Appendix E** for more information.

Recommendation #4: Establish new MNG expansion criteria

Opportunities

Expanding eligibility for MNG would address important needs of some otherwise excluded Vermonters, delay financial destitution or reliance on Medicaid long-term, support caregivers in maintaining their health, ability to work and support their families, and provide important outreach and education not only for current people in need but for future generations of caregivers and people in need of HCBS.

Challenges

- Any modifications to current eligibility would require research, development, and agreement on details; in particular, for a buy-in/cost sharing structure.
- There are limitations in Vermont's current information technology (IT) system that would create a barrier to any eligibility changes until the new system is in place.

Recommended Policies

4a. Provide training and supports for family caregivers regardless of income, basing eligibility solely on the ADL/IADL/SDOH needs of the family member being cared for.

4b. Add a buy-in/cost-sharing option or sliding scale for Vermonters over income but who meet clinical eligibility criteria.

4c. Modify MNG financial eligibility criteria to include the following specific changes:

- Raise the resource cap/asset limit from \$10,000 to \$20,000, or other reasonable increase based on a cost-of-living adjustment.[20]
- Update the MNG financial application to clarify that non-liquid assets such as IRAs, 401Ks, and 529 plans are already disregarded. It is only the distributions received from said non-liquid assets that are counted as monthly income.

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[20] The Bureau of Labor Statistics CPI Inflation Calculator factors \$10,000 in 2005 equating to approximately \$16,000 in 2023.

- Create an FAQ document that provides clearer guidance on what assets, funds, and resources are considered in the MNG financial eligibility self-attestation.
- Consider adding an income adjustment for housing costs (e.g., rent, and certain multi-generational factors and financial obligations).
- Develop clearer guidance on the self-attestation process and ability of MNG providers to begin providing services pending ASD eligibility approval upon the case manager's completion of the clinical and financial eligibility screening and the applicant appears to meet requirements.
- Explore the possibility of waiving MNG financial eligibility for people who are clinically eligible and have been determined to be self-neglecting, as defined by the Vermont Self Neglect Working Group as "An adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks".[21]

Policy and Fiscal Requirements and Implications

A buy-in/cost sharing structure will affect the MNG State funding allocation.

Recommendation #5: Create a new Medicaid eligibility category within Vermont's 1115 Waiver

Opportunities

A new Medicaid eligibility category would provide limited benefits (more limited than MNG), for people who do not currently meet Medicaid financial eligibility but are at risk of becoming eligible. By creating a new eligibility category with specific criteria for enrollment that includes financial, clinical, and SDOH / HRSN criteria Vermont can be even more proactive and preventative by supporting individuals at risk of becoming eligible for Medicaid in the future.

Challenges

- Such a change requires significant planning and negotiation with the Centers for Medicare & Medicaid Services (CMS).
- There are limitations in Vermont's current Medicaid eligibility system for the creation of new eligibility categories that would create a barrier to any eligibility changes at this time.

Current Policies

N/A

Recommended Policies

5a. Create rules that define the Medicaid eligibility category.
5b. Consider implementation of a pilot project with the new eligible population to measure the impacts of this change. The pilot project findings could be completed by the next 1115 Waiver renewal and if favorable and supported, could be included as a new population in the next 1115 Waiver.

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[21] Report to the Vermont Legislature. (2022). Recommendations Relating to Self-Neglect in Vermont, p.6.

Policy and Fiscal Requirements and Implications

- As a fixed part of the Medicaid budget, this change would require ongoing funding.

Recommendation #6: Building on other Vermont initiatives and studies, strengthen outreach, awareness, education, and referral related to LTSS and HCBS services and supports.

Opportunities

Across all meeting topics the workgroup raised concerns about MNG policies being unclear, unofficial, or generally not well understood. There is also a general lack of awareness of available LTSS and HCBS options. A focused and ongoing series of efforts to update and clarify policies and broaden outreach and education will raise awareness of options available to Vermonters and allow for an increase in referrals. There are many factors that impact appropriate and timely referrals including staff turnover and the costs associated with training for new staff, a lack of cross training across organizations, and missing policies and procedures for helping people on the phone before passing them to the appropriate organization for assistance. There are opportunities to address these challenges by strengthening the existing infrastructure of access points as well as building upon other initiatives such as Age Strong VT, and any future studies and corresponding recommendations in this area.

Challenges

- Costs associated with cross-training, including staff time to develop and participate.
- Keeping information current and sharing changes across organizations.
- Organizational capacity to dedicate resources to such recommendations.

Current Policies

The recommended key touchpoints all play a key role in providing information, assistance, and referral to Vermonters today.

Recommended Policies

6a. Review all written MNG policies and update as needed.
6b. Review and update all public-facing websites containing MNG information.
6c. Consider implementation of cross-training opportunities among existing key community organizations including 211, the AAA and HHA networks, VCIL, BIAVT, Alzheimer's Association. Record trainings so they are available to all new staff. Cross-training topics could include overviews of populations served, mission, services and programs offered, where to find online resources to share with callers, and any existing referral best practices and protocols.
6d. Promote primary community access points through existing networks such as website links to other community-based organizations and resources.
6e. Share program resources and outreach and education collateral with local connectors such as town offices (e.g., town clerk, town nurses), libraries, emergency responders, primary care practices, shelters, places of worship, community centers, as examples.

Policy and Fiscal Requirements and Implications

Each of the key touch points has limited resources dedicated to the provision of information, assistance, referral, and outreach and education. Currently there is not a comprehensive funding stream or budget line item supporting the delivery of statewide outreach, awareness, education, and information for LTSS and HCBS.

Recommendation #7: Clarify Dementia Respite Grant eligibility requirements.

Opportunities

There are many Vermonters with dementia that are undiagnosed. The cost of receiving an actual diagnosis can be very costly and often unaffordable for many, although there is an ongoing effort to make diagnoses more available through primary care providers. There currently exists a lack of knowledge regarding the requirements to qualify for the Dementia Respite Grant, which can include a formal diagnosis, a treating physician's note that states 'consistent signs of cognitive decline or impairment', or by failing the VT Mini-Cog test.[22] Clarifying the requirements for this program will benefit caregivers as well as expand access to people with dementia who might otherwise be unaware of, or be unclear on, the requirements for this program and its many benefits.

Challenges

Ensuring AAA staff are adequately trained in the administration of the VT Mini Cog test.

Recommended Policies

7a. Clarify requirements for the Dementia Respite Grant program.
7b. Change written DRG policy to confirm that results of the VT Mini Cog test are an appropriate indicator of dementia per the Dementia Respite Grant eligibility requirements.
7c. Change written DRG policy to confirm that appropriately trained AAA staff may administer the VT Mini Cog test.

Policy and Fiscal Requirements and Implications

The Dementia Respite Grant Program is currently funded with limited general fund dollars. While not formally changing eligibility criteria, clarifying guidance and allowing AAA staff to use the VT Mini Cog test results could greatly expand the number of people who have access to this program, thus reducing the number of persons that might be served, or risk not serving those individuals in greatest need.

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[22] Understanding & Administering the Vermont Mini-Cog - YouTube

Appendix A: Extending HCBS Workgroup Membership List

Name	Organization/Affiliation
Meg Burmeister	NEK Council on Aging
Erin Roelke | Diana French	Age Well
Jill Mazza Olson | Eric Covey	VNAs of Vermont
Kaili Kuiper	VT LTC Ombudsman Project
Marie Lallier	VT Council of Developmental and Mental Health Services | VT Care Partners
Sarah Launderville	VCIL
Jess Leal | Elizabeth Reagle | Ashley McCormick	BIAVT
Ruby Baker	COVE
Liz Genge | Molly Dugan	SASH
Kristin Bolton	VT Association of Adult Day Services
Meg Polye	Alzheimer's Association
Carrie Wulfman	OneCare
Jeanne Hutchins	UVM Center on Aging | UVM Memory Program
Pamela Smith	Consumer
Jane Dwinell	Caregiver
Angela McMann	DAIL
Angela Smith-Dieng	DAIL
Megan Tierney-Ward	DAIL
Mary Hayden	VT Association of Area Agencies on Aging
Mary Graham-McDowell	Rutland Mental Health Services
Joshua Slen	HST
Heather Johnson	HST
Julie Trottier	HST
Adriana Boroff	HST

Appendix B: Extending HCBS Workgroup Charter

December 2022

Project Background:

Act 167 (S.285) Section 8 requires that as part of developing the Vermont Action Plan for Aging Well required by the Older Vermonters Act (Act 156 of 2020), DAIL must convene a working group to consider extending access to long-term home- and community-based services and supports to a broader cohort of Vermonters who would benefit from them, and their family caregivers. A report of recommendations must be submitted to the legislature by January 15, 2024.
The VT Extending HCBS Stakeholder Work Group is tasked with providing input to DAIL, Adult Services Division (ASD), via collaboration with their contractor Health System Transformation, LLC. HST will prepare the report and recommendations per Act 167 and submit to DAIL by November 15, 2024.

Project Vision:

Vermont's vision for this project is to realize a long-term home and community-based services system that may extend supports to a broader cohort of Vermonters, including their family caregivers. The recommendations for such a system are derived through a transparent process using stakeholder input coupled with research on the most current and available data, evidence-based/informed programs and practices, and strategies that have been successful in other states; and review of the current Moderate Needs Group program, including related to eligibility, waitlists, funding distribution, and services, with identification of key gaps and suggested improvements.

Work Group Purpose:

Provide input to DAIL for the purpose of assisting in the development of a report to the Legislature as required in Act 167 of 2022.

Key Assumptions:

- The work group conversations will be guided by the ask as described in Act 167.
- DAIL and HST are available to provide answers to questions asked in order to facilitate work group discussions, to the extent their resources allow.
- Workgroup meetings and discussion will be limited to the topics outlined in advance of each meeting.
- Written comments focused on the work group meeting topics are an accepted method of input.
- Agendas will be posted in advance.
- Meetings will be recorded, and meeting minutes will be taken. Both will be posted online for public access.

Charter Purpose:

This charter serves the following purposes:

1. Provides a roadmap and outline for the active engagement of a representative group of vested parties in the development of recommendations for VT's HCBS system of services and supports.
2. Provides a structure, set of expectations, and prescribed processes and preferences to ensure meaningful feedback and the sharing of ideas and recommendations that will affect the desired systems change.

Meeting Ground Rules:

1. All constructive input is welcome.
2. Embrace diversity of ideas-listen and accept differences of opinions.
3. Share openly and meaningfully.
4. Be on time and come prepared for topics of discussion. Review prep materials ahead of time.
5. Homework assignments are important. Please follow through on your assignment(s) or let HST know as soon as possible if you are unable to fulfill your assignment.
6. Please be present and practice active listening.
7. Please mute/turn off all smartphones and other "work-related" devices, barring necessary emergencies. Everyone's time is valuable, and your attention is valued and respected.
8. All meetings will be facilitated with an agenda and be followed by meeting summaries and appropriate documentation for communication.
9. Meetings agendas and materials will be distributed at least 1 week in advance of meetings. Meetings summaries and accompanying documents (as applicable) will be shared within 1 week after scheduled meetings.
10. As a key liaison to your agency, organization, or community, you are accountable for communicating the content, decision points and action steps of meetings to all appropriate parties within your agency, organization, or community, as applicable.
11. All contact with HST should be directed to Adriana Boroff at adriana.boroff@health-system-transformation.com.

Meeting Agenda Format:

1. Welcome, Introductions, and Meeting Objectives
2. Review Outstanding Action Items
3. Presentation of Background Research, as applicable
4. Topic Discussion (as outlined below)
5. Review Action Items, Responsible Parties and Review Topics for Next Meeting

Meeting Schedule and Topics to be Discussed:

The first meeting will be held as a hybrid in-person/Zoom meeting. The work group will decide whether to proceed with hybrid meetings or all via Zoom going forward.

Meeting	Date	Meeting Topic to be Discussed
1	January 30, 2023	The types of services, such as those addressing activities of daily living, falls prevention, social isolation, medication management, and case

	1:00 – 3:00pm ET Meeting Room to be added	management that many older Vermonters need but for which many older Vermonters may not be financially eligible or that are not covered under many standard health insurance plans
2	February 27, 2023 1:00 – 3:00pm ET	The most promising opportunities to extend supports to additional Vermonters, such as expanding the use of flexible funding options that enable beneficiaries and their families to manage their own services and caregivers within a defined budget and allowing case management to be provided to beneficiaries who do not require other services
3	March 20, 2023 1:00 – 3:00pm ET	How to set clinical and financial eligibility criteria for the extended supports, including ways to avoid requiring applicants to spend down their assets in order to qualify
4	April 17, 2023 1:00 – 3:00pm ET	How to fund the extended supports, including identifying the options with the greatest potential for federal financial participation
5	May 15, 2023 1:00 – 3:00pm ET	How to proactively identify Vermonters across all payers who have the greatest need for extended supports
6	June 26, 2023 1:00 – 3:00pm ET	How best to support family caregivers, such as through training, respite, home modifications, payments for services, and other methods
7	July 17, 2023 1:00 – 3:00pm ET	The feasibility of extending access to long- term home and community-based services and supports and the impact on existing services
8	August 21, 2023 1:00 – 3:00pm ET	Potential changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication

Appendix C: Extending HCBS Workgroup Meeting Notes

Table 1. Extending HCBS Workgroup Meeting Topics and Framing Questions

Meeting Number	Topic (as outlined by Act 167, Section 8)	Framing Questions
1	The types of services, such as those addressing activities of daily living, falls prevention, social isolation, medication management, and case management that many older Vermonters need but for which many older Vermonters may not be financially eligible or that are not covered under many standard health insurance plans	What are the barriers to receiving these services?
		Which populations are most disenfranchised or experiencing the greatest difficulty in accessing these services
		What are the unique regional or cultural factors that impact older Vermonters' ability to access these types of services?
		What social determinants of health (SDOH) factors impact access? Why?
2	The most promising opportunities to extend supports to additional Vermonters, such as expanding the use of flexible funding options that enable beneficiaries and their families to manage their own services and caregivers within a defined budget and allowing case management to be provided to beneficiaries who do not require other services	After analysis, review, and discussion of use of such supports, specifically flexible funds historically – what has worked and what hasn't worked?
		What are the direct workforce challenges Vermont is experiencing today (and into the future) and what extended supports could help mitigate these challenges?
		What are the lasting COVID-19 and pandemic-facing challenges that should be addressed prospectively?
3	How to set clinical and financial eligibility criteria for the extended supports, including ways to avoid requiring applicants to spend down their assets in order to qualify	Are there any necessary changes to current clinical eligibility criteria to support a broader cohort of Vermonters?
		Are there any additional factors to consider (e.g., creative alignment of criteria) that supports an expanded population? Any unique criteria for specialized populations?

		Are there current financial eligibility criteria that promotes or lacks protection for Vermonters to spend down in order to qualify for services? Are there any adjustments that should be made to accommodate the current fiscal and economic reality?
4	What are the current challenges with funding, and what are the opportunities for change?	What are the biggest challenges and barriers of existing funding vehicles?
		What are the most promising strategies and approaches to overcome these barriers and challenges?
		What funding innovations are of greatest interest for further exploration?
5	How to proactively identify Vermonters across all payers who have the greatest need for extended supports	How do we define "in greatest need"? What does this mean to you?
		What data sources are most important to consider for identifying this population?
		Where and how would this data be accessed and used?
		What other new strategies, in addition to data sources, can be used to identify this population?
6	How best to support family caregivers, such as through training, respite, home modifications, payments for services, and other methods	What are the current barriers caregivers experience in accessing already available resources?
		What are the gaps?
		What are the most promising strategies and approaches to best support family caregivers?
7	The feasibility of extending access to long- term home and community-based services and supports and the impact on existing services	Is it feasible to extend access to long-term HCBS?
		What would be the impacts on existing services that need to be considered?

8	Potential changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication	What are the best or most effective current service delivery practices?
		What are the possible changes to service delivery?
		What are some high impact, low-cost changes?
		What are some high impact, high-cost changes?

Meeting #1

DAIL Extending HCBS Working Group
January 30, 2023
Meeting #1 Summary

Attendees:

Affiliation/Organization	Name
NEK Council on Aging	Meg Burmeister, Executive Director
Age Well	Erin Roelke
VNAs of Vermont	Jill Mazza Olson Eric Covey
VT LTC Ombudsman Project	Kaili Kuiper, State Ombudsman
VT Council of Developmental and Mental Health Services	Marie Lallier, Director for Developmental Disability Services
VCIL	Sarah Launderville, Executive Director or Peter Johnke, Deputy Director
BIAVT	Jess Leal, Director
SASH	Liz Genge
VT Association of Adult Day Services	Kristin Bolton
Alzheimer's Association	Meg Polyte, Director of Policy & Pamela Smith
OneCare VT	Carrie Wulfman, MD
Caregiver	Jane Dwinell
Consumer	Pamela Smith
UVM Center on Aging	Jeanne Hutchins, ED of Center on Aging/Caregiver Center
	Mary Hayden
Rutland MH Services Community Care Connection	Mary Graham
DAIL	Angela Smith-Dieng
DAIL	Angela McMann
DAIL	Megan Tierney - Ward
HST	Joshua Slen
HST	Heather Johnson
HST	Julie Trottier
HST	Adriana Boroff

Meeting #1 Topic: The types of services, such as those addressing activities of daily living, falls prevention, social isolation, medication management, and case

management that many older Vermonters need but for which many older Vermonters may not be financially eligible or that are not covered under many standard health insurance plans.

Framing Question #1: What are the barriers to receiving these services?

- Adult day can serve more people however some people have just a little too much money to qualify for MNG. More people do need the service (adult day), and if they were eligible for MNG we could enroll more.
- We are developing services and systems in response to Medicaid eligibility, and that is a barrier as people age.
- There is a shortage of home care providers, and so those with more significant disabilities are going to nursing homes.
- As a caregiver, we were never told about these services by our providers. Need more training or other help for providers.
- Age. Younger people with 'older' disabilities such as Alzheimer's can't access all services such as case management.
- Multigenerational families with multiple responsibilities jobs, children, older parents, etc. family system need.
- Financial barriers, families must 'drive to poverty' to be eligible for services. Need a buy-in mechanism.
- Because of workforce shortages, care is being rationed even for those who are already on the program. Is there another way to serve those people?
- System is so complex that if you have dementia or are sick or a caregiver it's difficult to go through websites, see options. The internet in general causes stress for some people. One of the barriers is the complexity of the system and multiple points of entry. Overwhelming and almost exclusively web based; makes it difficult for older people.
- Needs change for people, they are not stagnant. Finding one resource may not be enough over time.
- The person needing help and their working family caregivers have difficulty navigating the system and finding services.
- Dept of Health is considering training for primary care providers to give more guidance when there is a diagnosis of dementia. The intent is to have PCPs trained to help patients and families navigate the system. Are there education and cross pollination potentials?
- One barrier to MNG services today is the fee-for-service billing structure and requirements for Medicaid billing to get the federal match.

Overarching themes from 'barriers' discussion:

- Affordability
- Buy -in option is lacking/sliding scale.
- System of services developed in response to Medicaid eligibility which doesn't meet all needs (may be related to need for federal match).

- Providers don't always know about or successfully pass along information about services to their patients/clients.
- Younger people with dementia are not eligible for all services; younger people with chronic conditions are often not considered when planning for HCBS services.
- Complexity of system makes it difficult to navigate, especially for people in need and caregivers with multiple family responsibilities like jobs and children.
- Web-based information difficult to navigate for those with limited skills, knowledge, or internet access. Vermonters must self-rely on internet and technology to learn about services and options due to lack of integrated or 'one stop shopping'.

Question: Which populations are most disenfranchised or experiencing the greatest difficulty in accessing these services?

- People with multiple disabilities – e.g., developmental and physical – they have issues accessing services.
- With current structure it's almost always difficult to see what is the source of the condition/service need and that brings challenges with how services are provided and funded.
- People socially isolated have hard time navigating resources. Once connected we do a good job.
- People with mental health and physical health needs have challenges accessing services. Can be denied services, or, the systems point to each other as the primary responsible entity to address needs. No one taking responsibility.
- Challenges with how we get info to people. Relying on technology that isn't accessible to people. Transportation is a challenge. Isolation. Stigmatization of needing things – everything is ok, but we'll buckle down and do it. Overcoming stigmatization. Right to ask.
- Vermont culture and 'fierce independence'.
- Abuse by caregivers: people feel they can't say anything about it or will lose the caregiver support.
- New Americans, immigrants, and non-English speaking populations may have difficulty accessing services. Also, social isolation – people who don't know how to access services and are at high risk of needing support are more likely to have nutrition and falls problems.
- Some exploitive families who keep family members cut off. For example, they can't get a guardian before age 60 but some need it younger. Worry about those families. Mental health plays a role. Families come into the ER with a dementia person and don't know what to do. Hospital doesn't want to take them. Nursing home doesn't want them because of their major mental health issues.
- Some people have misinformation about the LTC system and make decisions based on bad information. For example, unrealistic fears of losing their property and savings. Need more education.

- Substance abuse issues can interfere with getting services to people, and it leads to people not engaging.

Overarching themes from ‘disenfranchised populations’ discussion:

- Multiple conditions/disabilities, especially a combination of mental and physical health conditions, can interfere with accessing services because of difficulty assessing the root cause of the service need and appropriate delivery system/funding source.
- Social isolation causes people to remain disconnected from needed services.
- New Americans and people with limited English proficiency can have difficulty understanding and accessing services.
- Substance abuse issues can keep people from engaging with systems of care.
- Stigmatization and fierce independence keep people from accessing needed services.
- Misinformation about the LTC system, such as fears of losing property and savings, keeps people from accessing needed care.

Question: What are the unique regional or cultural factors that impact older Vermonters’ ability to access these types of services?

- Different regions of the state provide different services, for example there are more SUD services in one county vs another. Even services available statewide do not offer the same services (e.g., home health/VNA)
- The workforce crisis can’t be overstated, sometimes there are no applicants for advertised positions, even when agencies paying more than their costs. There are regional differences in workforce pressures and an agency’s ability to subsidize wages. All VNAs are losing money to some degree.
- As a society caregiving is not seen as something ‘amazing’ compared to other countries like Japan where it is more prioritized.
- Cultural identity around race, sexuality, new Americans.
- Vermont culture of fierce independence. For example, a Vermonter who won’t tolerate receiving care at home (privacy and stigmatization) so had to go into memory care facility. People think they can do more than they can.
- Urban/rural divide, for example Vermonters living in the NEK are less likely to want, accept, or reach out for help. It seems Vermonters living in more urban areas seem to be more willing to accept or reach out for help.
- We are struggling to provide help to people who want it, particularly rural communities. No corner of the state that doesn’t have a greater need than can be met.

Overarching themes from ‘regional and cultural factors’ discussion:

- Variations in services offered and availability in different parts of the state.
- Workforce pressures are different, more or less severe in different parts of the state.
- Caregiving is not prioritized in our culture.

- Vermonters with a ‘fierce independence’ identity, especially in more rural areas of the state.

Question: What SDOH factors impact access? Why?

- Meals on Wheels can’t accommodate special dietary needs of some people (and when you are a person with Alzheimer’s and is not stove safe and need to rely out outside meals), which leads to personal cost to hire someone to shop and cook. Lots of older adults are on medical diets, but not all can be accommodated by Meals on Wheels.
- Housing is a factor for individuals. When people are homeless, they lose access to services that can’t be delivered without a home. Housing retention services are needed. For example, clutter piling up leads to eviction.
- Transportation is a significant barrier in rural communities and is often needed to address other SDOH gaps.
- Talking to people on the phone or zoom to screen is good but being in the home provides more beneficial information.
- Employment, volunteering should be on the list.
- People can’t afford insurance and so buy a high deductible plan and then can’t afford to participate in things like caregiver groups because of deductible.
- People whose primary source of heat is wood is a problem if they can’t physically move wood into the house. Or people who keep house cold to save $.
- Broadband access is unequal, which effects social engagement and telehealth.
- People with memory issues who don’t have anyone to come to their medical appointments with them and they cannot remember what is said at a doctor’s appointment and needs a second person to take notes. The doctor/office does not provide any assistance beyond follow-up notes that are not easy to understand. This can lead to errors in decision-making, taking wrong medications, taking action that could harm.

What services are needed that Vermonters cannot currently get or for which there are barriers?

- PACE was a program that could use $ for flexible services needed. It met people where they are at.
- The idea of ‘in lieu of services’ is a good idea.
- More flexible funds. Expanding the MNG flex funding has been very helpful to creatively meet client needs that otherwise wouldn’t be met, e.g., with just homemaker program.
- Personal emergency response systems are needed.
- Medication management – need someone to pre-fill medication boxes. One piece missing is ongoing support.
- Longitudinal care program funded through One Care, expands Medicare benefit under skilled services (Medicare rules are narrow). Allows people to continue over long period of time with personal care or nursing beyond what Medicare will allow/pay for.

- CFC typically managed as one big budget. MNG is a small part of that. Talking now about best use of those funds.
- Home modification programs are inadequate. If we can help with fall prevention and make a kitchen accessible it can reduce reliance on meals on wheels and other programs.
- Transportation can help people choose to not be isolated if they have transportation to church, movies, etc.
- Need increased access to ASL interpreters. Medication visits are covered, but for things not required like AA meetings, for example, there is no way to pay for that.
- Foot care
- Budget: there is underutilization of MNG (lack of workforce and other factors as well). As a result, 2024's budget is being recommended for reduction.

Overarching themes from 'SDOH' discussion:

- Nutrition: Meals on Wheels is good but not all diets can be accommodated. Home modification programs that make kitchens more accessible and transportation to grocery stores can reduce reliance on that program.
- Housing: Housing retention services like helping people reduce their clutter to avoid eviction; help with converting heating from wood for people who can't physically do that work; avoiding homelessness helps maintain access to needed home-based services.
- Transportation: A big problem in rural areas. Needed to reduce isolation and other SDOH gaps.
- Broadband access: Unequal across the state and reduces access to telehealth and increases social isolation.
- Translation services: people with Alzheimer's need an additional person at medical visits to take notes so they won't forget instructions; ALS and other language support covered at medical visits but needed in other situations like AA meetings.
- Home modification programs: needed to make homes safer and more accessible, which can reduce reliance on other programs.
- Personal emergency response systems: more are needed.
- Medication management: ongoing support needed to fill pill boxes and use existing technology.
- Flexible funding: seen as key to successfully meeting needs as they arise.

Meeting #2

DAIL Extending HCBS Working Group
February 27, 2023
Meeting #2 Summary

Attendees:

Affiliation/Organization	Name
Age Well	Erin Roelke
VNAs of Vermont	Jill Mazza Olson
VT LTC Ombudsman Project	Kaili Kuiper, State Ombudsman
VT Council of Developmental and Mental Health Services	Marie Lallier, Director for Developmental Disability Services
VCIL	Sarah Launderville, Executive Director or Peter Johnke, Deputy Director
BIAVT	Jess Leal, Director
SASH	Molly Dugan
VT Association of Adult Day Services	Kristin Bolton
Alzheimer's Association	Meg Polyte, Director of Policy
OneCare VT	Carrie Wulfman, MD
COVE	Ruby Baker
Caregiver	Jane Dwinell
Consumer	Pamela Smith
UVM Center on Aging	Jeanne Hutchins, ED of Center on Aging/Caregiver Center
V4A	Mary Hayden
DAIL	Angela Smith-Dieng
DAIL	Angela McMann
DAIL	Megan Tierney - Ward
HST	Joshua Slen
HST	Heather Johnson
HST	Julie Trottier
HST	Adriana Boroff

Meeting #2 Topic: The most promising opportunities to extend supports to additional Vermonters, such as expanding the use of flexible funding options that enable beneficiaries and their families to manage their own services and caregivers within a defined budget and allowing case management to be provided to beneficiaries who do not require other services.

State Innovations Comments

- Under COVID 19 what did VT do? Increased utilization limits with home modification and assistive technologies and streamlined enrollment. Loosening of caregiver requirements such as allowing spouses and guardians to be paid.
- 1,000s of exceptions and expansions for state requirements were granted by CMS during the pandemic and we know a great many of those are going to revert. There are a number of challenges that state laws will have to catch up with including licensing expansions, out of state providers. Some states allowed spouses to take care of loved ones but that is not typically allowed. Many things will require policy conversations. One take away is to work with DAIL and identify strategies specific to LTSS that we did so that we can have that list. We can get that information before the next meeting.
- Expanding settings has federal implications. Providing HCBS in acute settings impacts MCOs and what states pay to MCOs. Different pieces must be acted upon. Expanded telehealth will be continued by a lot of states. Telehealth includes a lot about what is not included as telephonic at all but is remote monitoring and video, etc.

Framing Question #1: After analysis, review, and discussion of use of such supports, specifically flexible funds historically – what has worked and what hasn't worked?

- Two remaining barriers for MNG:
  - Low asset threshold
  - Long waitlist: 47 in Addison County. Waitlists could transcend multiple years.
- Cultural competency and marginalized populations need to be represented
- Transportation for people not Medicaid eligible. Are there services for people not eligible vs the person? What type is the highest priority?
- Transportation in rural counties is difficult, and there is a lack of bus routes and schedules. This impacts the ability of people to socialize. We need advocacy. On demand services like Uber are better than schedules. The bus system isn't the most efficient system to support small towns.
- Addison County is having a hard time getting volunteer drivers. Even medical rides aren't being provided.
- Adult Day Services (ADS) rely on transportation funds to pay for buses to pick up people and is part of respite. It may not be how they commonly use it, but it is very important to their work. They could investigate how much gets spent per person.
- We have more flexibility in shifting funds now compared to several years ago. Funds are allocated to all ADS and funds can shift between ADS and home health services (HHS) throughout the year. Some agencies have asked for funds to be transferred on an individual basis (participants) as we don't want people changing case management agencies (CMAs) to access flex funds.
- Even though there are improvements in managing flexible funds at the agency level those shifts can be difficult to manage. The process is still administratively

burdensome. It is difficult to transfer unspent funds. If we are in mid-year or can only transfer once per year, this limits funding that can be used if we're approaching the end of the budget year. This is one of the biggest barriers.

- ADS are very grateful for the flexible funds as it allows more people to come to ADS, but if we're not going to do that anymore and lose access to funds that would be unfortunate for people. If we knew the status of funding earlier, we could transfer funds earlier and that would be very helpful.
- We should consider prioritization of the MNG waitlist.

Menti Poll: Rank flexible services of greatest importance and discussion
The Teams poll yielded the following rankings.

1. Personal care, respite, companion services, homemaker
2. Transportation (for medical or non-medical purposes)
3. Defined budget to use flexibly
4. Technologies that support individuals with ADLs/IADLs
5. Home modifications or other adaptations
6. Transition or sustainable housing services and supports
7. Nutritional supports or home delivered meals
8. Purchasing home goods or appliances

The following discussion ensued for most of the meeting with additional and more specific ideas put forth for flexible funding and other considerations for expanding HCBS.

- We need to pay family caregivers and that is a good use of flexible funds.
- If there is a decline in use of MNG due to the workforce shortage, personal care and companion services-all of which are 1:1 services, ADS provides a lot of what people would receive with companion services in a group setting, which also helps with social isolation. Group services could help address the challenges with the workforce, companion services and personal care.
- Communication access and expansion of ASL interpreter services. Transportation and language/communication accommodations are only purchased by Medicaid when it's a medical need.
- Service animals are important. Anything that expands flexibility for people directing their own services is number one priority. At VCIL we received federal funds where we could be very flexible and it allowed people to have options that they didn't have before. Many are on this list but sometimes had something that could be more flexible. Continuing to grant more flexibility.
- Flexibility in use of funds should be first so people can choose whatever they want. It is interesting that there was an 8% decline in MNG enrollment overall in 2021. We've seen substantial increases in enrollment in MNG for flex funds in 2019. As the workforce is challenged in HHAs, flexible funds have allowed people to fill the gap.
- Anecdotally, the decrease is partially fueled by policy that states that participants must have a service in addition to CM. A lot of people were terminated b/c a service wasn't available or they couldn't hire someone or find someone to hire. That was

seen frequently this year where participants were terminated b/c they were not active on another service except for CM.

- We have a blue-sky opportunity to talk about what would prevent people from graduating to MNG or SNG. Things that are preventive such as healthy foods, exercise, healthy checkups are all fair game for this discussion. These are things that should be discussed and whether they can ultimately be funded by the state.
- We need to start to think of the "how to". How much of these ideas are about expanding existing services (e.g., transportation) vs getting money in the hands of people to use directly for things not covered.
- Use funds to address communication and broadband access challenges, phone reimbursement for people to access social opportunities, telehealth options that would allow for video.
- Providing more funding directly to people reduces the overhead to agencies who are currently receiving the funding and then distributing it.
- When we talk about defined budgets to use flexibly, would there be "not allowable things"? Or at the discretion of the person or CM?
    - There are existing limitations for how to spend money under flexible choices. That would continue to exist.
- We should consider expanding the cap. $3500 is a soft cap, but language right now in regulations is that agencies cannot exceed awards if there is a waitlist. Because agencies are often using flexible funds to pay for ongoing services the amount of services that people can receive has shrunk in recent years. For example, participants used to receive weekly services and are now receiving services every other week. The program is becoming less effective in service of its intended purpose to prevent higher levels of care.
    - We shouldn't use $3500 as a benchmark for the future. There are also huge variations in the costs of services.
- We should think about supports that are not pulling on the existing workforce. We're seeing an increase in demand for personal emergency response systems (PERS) and this is currently covered under MNG flex funds. Could this be expanded to more people? This would really help people to feel safe and secure at home and would help with getting services if they fall.
- Another idea is funding medical alert bracelets and the engraving costs. This is a huge benefit for people at risk of getting lost. They are relatively cheap but for some people they are expensive. Family members feel comfortable leaving someone home who might have early cognitive impairments if they know they are wearing one.
- Outside of the standard PERS, companies now offer expanded services like reminder calls for taking medications that eliminates the need for someone to come to their home. People can get a call at a reasonable price. There are even some more advanced medication distribution products that offer help with polypharmacy etc., but these often have an ongoing subscription cost.

- Providing remote programming for people in ADS because of help with funding and providing iPads, older people with cognitive issues have a hard time using technologies. It is great to have the capacity, but it's not always easy for them to operate, also for persons with tactile issues. There is an ableness we might be assuming with using technology.

Framing Question #2: What are the direct workforce challenges Vermont is experiencing today (and into the future) and what extended supports could help mitigate these challenges?

- Payment for personal care: is there a cap on how much individuals are paid?
    - In ARIS, $25/hour is the maximum however this is usually for the High and Highest Need groups. We usually don't see that in MNG. We usually see needs that are moderate and it is not always personal care. It includes things like going to the grocery store, cleaning the house. Participants can hire employees for under $25 and pay the invoice to the agency, not to employee directly.
- For agencies not being able to staff, it is helpful to not have to go through an agency and pay someone directly at a good hourly rate.
- How much we pay workers is an important piece and is a related piece with housing for the workforce. The workforce also needs to be housed and that is difficult to find these days.
- For HHAs, we've struggled to hire for the MNG. Agencies have tried hard and advocated for years for adequate funding and for MNG being especially underfunded. It isn't for a lack of trying or substantially subsidizing from Medicaid. HHAs are open to flexible funding and using these kinds of services. CM's from HHAs assist people using flex funds. There is concern around expanding flex funds as people don't have anyone to help. We're worried about expanding further as we are already struggling to care for people who are already eligible. We can't address the existing waitlist. If we have broad expansion when we can't do what is on the list.

Framing Question #3: What are the lasting COVID-19 and pandemic-facing challenges that should be addressed prospectively?

- The pandemic is not over. Whatever language we use in our report we need to acknowledge that. Many people are still being harmed due to the pandemic.
- Emotional health, mental health, wellness, and prevention: opportunities for people to participate in things that reduce social isolation. We learned a lot through COVID but these issues were exacerbated by COVID. Where does this fit in with flexible funds? If someone wanted to participate in evidence-based wellness program this costs money or if someone wanted to do physical fitness or be part of a community. We should focus on prevention as well.
- Not explicitly called out in policy and procedures if it's allowable but in person centered service planning (PCSP) with CM's they help the person identify unmet needs, identify their plan, and there are many things/services that are allowable but there is not an explicit list. It is very flexible.

Summary of Ideas from Workgroup Members:

List of Flexible Funding Considerations (Including Results of Poll)
• Personal care, respite, companion services, homemaker. • Transportation (for medical or non-medical purposes). • Defined budget to use flexibly (use of flexible funding going directly to participant). Defined budget means there would be non-allowable goods and services as currently in MNG policy. • Technologies that support individuals with ADLs/IADLs. • Home modifications or other adaptations. • Transition or sustainable housing services and supports. • Nutritional supports or home delivered meals. • Purchasing home goods or appliances. • Paying caregivers. • Communication access and expansion of ASL interpreter services. • Communication and broadband access challenges, phone reimbursement for people to access social opportunities, telehealth options that would allow for video. • Service animals. • Emotional health, mental health, wellness, and prevention. • Things that are preventive such as healthy foods, exercise, healthy checkups. • Supports that are not pulling on the existing workforce like PERS. Expand PERS more people. • Funding medical alert bracelets and the engraving costs. • Expanded services like reminder calls for taking medications that eliminate the need for someone to come to their home.

Meeting #3

DAIL Extending HCBS Working Group
March 20, 2023
Meeting #3 Summary

Attendees:

	Affiliation/Organization	Name
x	NEK Council on Aging	Meg Burmeister
x	Age Well	Erin Roelke
x	VNAs of Vermont	Jill Mazza Olson
x	UVMHN HHA	Christie Randall
x	Caledonia HHA	Rachel Lepine
x	Rutland MH Services	Mary Graham-McDowell
x	VT LTC Ombudsman Project	Kaili Kuiper
x	VT Council of Developmental and Mental Health Services	Marie Lallier
x	VCIL	Sarah Launderville
x	BIAVT	Jess Leal
x	SASH	Liz Genge
x	VT Association of Adult Day Services	Kristin Bolton
	Alzheimer's Association	Meg Polye
x	OneCare VT	Carrie Wulfman, MD
x	COVE	Ruby Baker
	Caregiver	Jane Dwinell
	Consumer	Pamela Smith
x	UVM Center on Aging	Jeanne Hutchins
x	V4A	Mary Hayden
x	DAIL	Angela Smith-Dieng
x	DAIL	Angela McMann
	DAIL	Megan Tierney - Ward
	HST	Joshua Slen
x	HST	Heather Johnson
x	HST	Julie Trottier
x	HST	Adriana Boroff

Meeting #3 Topic: How to set clinical and financial eligibility criteria for the extended supports, including ways to avoid requiring applicants to spend down their assets in order to qualify

Follow-up from Meeting #2:

- MNG has a waitlist and also for DD services.
- Regarding recommendations that do not pull on the direct care workforce, we need to consider all ideas going forward. We need to think outside the box and not stifle ideas. We should throw in all ideas and work toward expanding capabilities. Flexible services is so important.

Framing Question #1: Are there any necessary changes to current clinical eligibility criteria to support a broader cohort of Vermonters?

- MNG clinical eligibility is too broad. It is hard to find someone that is not eligible clinically. AgeWell hasn't yet tested its new prioritization criteria but will see if this changes the current reality.
- Some agencies are already prioritizing their waitlist using a prioritization tool. Both AgeWell and NEKCOA share their approaches. NEKCOA will send their tool and share with the group.
- Dementia respite grants have limited eligibility criteria due to requiring a diagnosis; are there other options or can primary care providers play a role? It costs money to obtain a diagnosis. Undiagnosed people could benefit from services but they can't access them without a diagnosis
- Criteria is simple and easy to understand and is good as is but need to think about the caregiver as well. How do we do that?
- MNG group offers multiple services and it looks different depending upon the provider (e.g., adult day vs HHAs that provide homemaker services).
- For HHAs, it would be burdensome to do a broader screening of individuals on the waitlist as they are not reimbursed for any screenings or assessments.
- It is better to support people sooner rather than later to avoid stress on families and the healthcare system later. The current clinical eligibility allows for that.
- Need to consider eligibility for the self-neglect population.
- MNG will see a change in eligibility in 2025, removing the need to have a chronic condition that requires monthly monitoring to a broader requirement for a person's health and welfare to be at imminent risk without services. The criteria will retain the "or" methodology across criteria.
- One area that needs to be considered that is not currently factored in is SDOH. Meg and Erin shared that their prioritization tools do factor this in, such as social isolation.
- Social isolation is very important to consider because people who are very socially isolated may have a lower level of need in ADLs and their IADLs, but what they need is completely unmet such as preparing meals.
- The NEK tool considered frequent PCP visits, ED visits, multiple medications, food insecurity, frequent falls, use of adaptive equipment, among other factors. Meg will send it over.
- ADS providers do consider SDOH such as serving people who lack access to healthcare and factors of poverty and rurality; help with economic stability;

connect to social and community supports; offer ADA and dementia-friendly environments; and education on a variety of issues.
- We should consider a person's mental health diagnoses.

Framing Question #2: Are there any additional factors to consider (e.g., creative alignment of criteria) that support an expanded population? Any unique criteria for specialized populations?

- For self-neglect populations over and under age 60 the determination that the AAAs do does not lead to access to additional services. There needs to be additional services for this population as they are at high risk for adverse health effects. Some self-neglecting individuals appear to have plenty of assets, but they lack the ability or the willingness to engage in services or they don't want to disclose their financial situation. Is there the possibility for the community to vouch for their situation to at least get services started?
- Early onset dementia populations face additional challenges for many are in the middle class and need case management services and incomes are too high to qualify for programs.
- Other younger populations impacted by acute events that turn into long-term functional limitations requiring supports (e.g., stroke, TBI)

Framing Question #3: Are there current financial eligibility criteria that promotes or lacks protection for Vermonters to spend down in order to qualify for services? Are there any adjustments that should be made to accommodate the current fiscal and economic reality?

- Spousal income disregard for MNG is too low. Consider following model of disregard on Medicaid side. What would be reasonable limits if there were disregards? Especially for younger persons with dementia and they have a spouse that still works and needs to provide care. With current criteria, they will have less retirement savings, they use their income to pay for services.
- The $140K+ spousal disregard in LTC Medicaid seems fair, allowing the spouse to be somewhat protected from spending down all their assets, particularly for people still working or have other obligations.
- For a couple where only one person is in the program, aligning requirements with the other spouse's eligibility requirements makes sense.
- $10,000 resource/asset cap is too low, particularly for the younger population with disabilities. Younger people often have other responsibilities including children or other spousal responsibilities or child support. $10K can be depleted very quickly - home repairs, paying taxes can easily consume that amount of money)
- Proposed funding cuts and impact on serving more people. Discussions of expanded eligibility amidst current cuts is a challenging conversation.
- Preserving housing is extremely important. Incomes may appear higher but housing costs reduce available funds to help support services.
- With presumptive eligibility, HHAs have concerns because case managers end up doing a lot of work which is not reimbursable.

- DAIL clarified that the "Waiver while waiting" program is VT's version of presumptive eligibility. This is different than the work that case managers do to help people apply. It is rare that a case management agency would do financial eligibility first and then clinical, send it in, and then be told by the state that the person is not eligible.
- The "Waiver while waiting" is also not about MNG.
- Need to consider multi-generational factors when looking at finances and financial eligibility.
    - For example, sometimes a grandparent's income is used to care for their grandchildren who live with them and this is not factored in. Primary care providers often have insight into these family situations. They can educate their patients about these programs, like MNG. However, due to the paperwork, referral process, and "red tape" needs for PCPs to refer, there are missed opportunities for people to get connected to needed services. Or a person's money is being used to pay for other family members' expenses.
    - If someone does have many household members, that is not part of the current picture. MNG only looks at the consumer and the spouse.
- Should consider patient share/cost sharing for MNG.
- We need to increase the hourly rate for workers from $15 to $20/hour. Subsidies could come from VT Health Connect.
- People who have assets are nervous about paying $19/hour for adult day even if it is needed. Is there the possibility for "membership" for occasional use?

Menti Poll #1: Clinical and Financial Strategies of Greatest Importance

- Self-attestation presumptive eligibility
- Creation of MNG homemaker program to be administered through a designated MH agency for clients served by those agencies.
- Higher spousal disregard, younger onset dementia eligibility, keep IADLs as well as ADLs
- The clinical eligibility based around need is paramount. As we work with people in the community and look to the MNG program, it is so critical to include IADLs more fully.
- Household multi-generational cohabitation can impact resources. How is that factored? Have you educated primary care providers enough? PCPs often have insight into household status.
- Waive financial eligibility for clients who are clinically eligibility and have been determined to be self-neglecting.
- Create income disregard for housing-related expenses for financial eligibility.
- Explore expanding OAA to younger adults.
- Remove financial eligibility criteria for Dementia Respite Grant due to the known financial impact that caregiving has on family caregivers.
- MNG has a Medicaid priority over people with Medicare. This is limiting and may not serve the individual with higher needs.

- I like the idea of cost share. I think raising the financial eligibility for MNG will help to serve those in middle class who are often not eligible for any services. Raise it to $60,000.

Menti Poll #2: Most Important Eligibility Considerations to Include in Report

- Increase $10,000 disregard for couples.
- Same as LTC eligibility for disregard
- Regarding assets, consider excluding savings like IRAs, 401ks, 529s.
- Consider risk of hospitalization, excluding more savings
- Other spousal custodial arrangements such as child support, alimony, and putting money into IRAs/retirement.
- Disregard $140,000 similar to LT Medicaid for the spouse
- Special eligibility criteria for clients determined to be self-neglect.
- Eligibility that considers the needs of both care recipient and caregiver
- Expand clinical diagnosis eligibility to include those such as MCI, mental health problems such as bipolar, perhaps post CVA impairments.
- Incorporate social isolation and unmet needs into clinical eligibility and/or prioritization.
- Similar to CFC high/highest, consider having DAIL assess clinical eligibility for MNG instead of relying on case management agencies.

Meeting #4

DAIL Extending HCBS Working Group
April 17, 2023
Meeting #4 Summary

Attendees:

	Affiliation/Organization	Name
x	NEK Council on Aging	Meg Burmeister
	Age Well	Erin Roelke
x	VNAs of Vermont	Jill Mazza Olson
	UVMHN HHA	Christie Randall
	Caledonia HHA	Rachel Lepine
x	Rutland MH Services	Mary Graham-McDowell
x	VT LTC Ombudsman Project	Kaili Kuiper
x	VT Council of Developmental and Mental Health Services	Marie Lallier
	VCIL	Sarah Launderville
	BIAVT	Jess Leal
	SASH	Liz Genge
x	VT Association of Adult Day Services	Kristin Bolton
	Alzheimer's Association	Meg Polye
	OneCare VT	Carrie Wulfman, MD
	COVE	Ruby Baker
x	Caregiver	Jane Dwinell
x	Consumer	Pamela Smith
x	UVM Center on Aging	Jeanne Hutchins
x	V4A	Mary Hayden
x	Brain Injury Alliance	Ashley McCormick
x	Brain Injury Alliance	Elizabeth Reagle
x	AgeWell	Diana French
x	DAIL	Angela Smith-Dieng
x	DAIL	Angela McMann
x	DAIL	Megan Tierney - Ward
x	HST	Joshua Slen
x	HST	Heather Johnson
x	HST	Julie Trottier
x	HST	Adriana Boroff

Follow-up from Meeting #3:
For people who are younger, the reason for the need for retirement account disregards is because they can't access that money. If it's currently disregarded, then that needs to be made clear in the MNG application. Also, people need assistance with completing the application.

Meeting #4 Topic: "What are the current challenges with funding, and what are the opportunities for change?"

Framing Question #1: What are the biggest challenges and barriers of existing funding vehicles?

- Funds that are budgeted are not utilized. People get sick, hospitalized, come off the program etc. so budgeting is nearly impossible. Agencies overcommit in order to get closer to funding to spend.
- The process of transferring funds from one organization to another takes a long time, adding to challenges.
- MNG is a capped program, which is different from the rest of CFC which is open ended re agencies. Different than other types of Medicaid reimbursement that agencies deal with.
- Brain Injury Alliance has clients who would benefit from case management and homemaker, and they are told they are way down on the waitlist. For those who do have MNG, a lot of them can't get services because there are no staff available. Needs are multi-faceted. Most of the caseload are younger than 65. A lot of clients get push back to receiving services because people think they don't need them. They have mental organizational issues.
- Home health agencies share everyone's frustration on how hard it is to get services, both direct service and case mgmt. They would support prioritizing waiting lists, but the challenge is that agencies don't have the capacity to reevaluate everyone's needs. It's a zero-sum game with the workforce.
- Is the issue not enough funding or not enough staff?
- The funding HHAs have is not easy to move around to other orgs who might make use of it. Also, the reason HHAs can't spend $ is because they can't find the workforce.
- Stand-alone case management is a big need.
- The assessment tool doesn't give enough direction in terms of ability to report on issues we are hearing from folks (e.g., brain injury and early onset Alzheimer's)
- Case management can't stand alone. It needs to be decoupled from other services
- Adult day is rebuilding after pandemic, trying to hit their allocation for the year without going over.
- Neuro Resource Facilitators work with emotional regulation and other issues such as executive function.
- The current program has coverage in state plan for limited scope of eligibility for those types of services needed by TBI (so maybe expand those limitations)
- How to create a program that meets as many needs as possible with limited funds. Entitlement available for those who meet high and highest or CRT. MNG has never

been deemed an entitlement. But there have been many changes since then (e.g., 1115 Waiver), so maybe revisit that designation.
- When new FY rates come in, it's often after the year has started. Reassessments are done prior to that which causes stress because we have to retroactively adjust, which impacts retention of workers.
- Accessing MNG funds are challenging. Moving funds from HHA to AAA is difficult.
- CFC currently has no strategy for determining rates of direct care providers and appropriate increases in rates. HHAs currently need 50% rate increase just to get to cost.
- Some Medicare Advantage plans are fine, but a large player in VT is paying lower than the M'aid rate. It's the biggest financial threat to home health that there is. No leverage, no negotiating power and state can't help.
- For some consumers, a few hours of help is better than no hours.
- Reporting can be a burden. Direct staff and service coordinators require over 200 reporting requirements across MH and DD services.
- For AAAs, fiscal intermediaries is a frustrating system but have been doing it for so long and have figured it out.

Framing Question #2: What are the most promising strategies and approaches to overcome these barriers and challenges?

- Have fewer entities manage the funding rather than have it spread out
- The challenge is that everyone is doing something different. Delivering different services, etc., This could be impacting service delivery. it might mean orgs that don't provide those services don't get funding and so those services aren't available.
- Consider having 'pass through' orgs rather than holders of the funds.
- Is there an example of a more direct avenue of giving money to people like 3Squares, that allows consumers to purchase what they need almost prospectively?
- We worked with staff and communities to get the word out about flex funds and the use of it. We have been successful with people hiring friends and family b/c homemaker services don't need trained caregivers to go shopping or clean a house.
- If we want to further explore moving to flex funds, will need to look at a team of HHAs providing direct services as to whether this makes sense. Uncomfortable with this group making that kind of decision. Need to talk about how to structure that.
- If there are funds left, is there a way to raise the reimbursement rate to direct service? It is currently not a living wage. If there are funds and there is a hiring problem, offer more money to make it more attractive.

Framing Question #3: What funding innovations are of greatest interest for further exploration?

- Vacancy rates, size of waitlist. Data is available on all of it.
- Consider the option to expand certain aspects like case management decoupled from services.
- There are so many people falling through the cracks b/c they are not eligible for anything. Some people are not in need of support for ADLs, but they suffer from executive functioning.

- Need to get CM through agency but there isn't enough CMs to serve everyone. Consider pass through flex funds to hire CMs if agencies don't have staffing to do it. There are already CMs that may be interested in a few hours a week outside their regular agency jobs.
- We don't have adequate tool to assess for or even figure in executive functioning.

Menti Poll #1 Results: Which funding innovations are of greatest interest?

1. Place all into flexible funds
2. Prioritize waitlist statewide.
3. Transfer funds to higher need areas if funds not used.
4. Expand services beyond what is already available.
5. Place half of funds out for use and see how are spent and based on use, distribute the balance.
6. Revisit VT Trust Fund idea
7. Engage health plans | ACOs in alternative funding strategies for non-Medicaid eligible.
8. Use HHA formula in similar way as AAA formula and same criteria (e.g., living alone, etc.)

Menti Poll #2 Results: Funding Challenges and Solutions

- The biggest problem I'm seeing is access to case management for folks who are not eligible for LTC Medicaid. I don't know solutions, maybe decoupling case management and services.
- Create an easy way for consumers to hire as we had with a previous database of caregivers, but it needs advertising.
- Funding is inadequate for all entities in the long-term care system. We need consistent funding that covers costs and is routinely updated. No easy answers.
- Flexible funding that creates a more nimble distribution of fund
- The biggest challenge is inadequate staffing. Spending flexibility may help.
- Getting case management --decouple or let us use flex funds to hire.
- Help us get background checks for private hire.
- Better pay for staff
- Financial eligibility - e.g., respite grants - separate funds for respite for all caregivers
- Need adequate funding, period. Across the board. Better pay for staff, a living wage. No idea how to do that.
- Allow for realization that $ if you hire, a fair amount is used up for aris
- More funding for flex funds
- Not all Home Health Agencies are willing to collaborate regarding unused funding, longer waitlists between AAA and HH. If able to collaborate more clients receive services/less waitlist.
- Anything to reduce administrative costs

Meeting #5

DAIL Extending HCBS Working Group
May 22, 2023
Meeting #5 Summary

Attendees:

	Affiliation/Organization	Name
	NEK Council on Aging	Meg Burmeister
x	Age Well	Erin Roelke
x	VNAs of Vermont	Jill Mazza Olson
	UVMHN HHA	Christie Randall
	Caledonia HHA	Rachel Lepine
x	Rutland MH Services	Mary Graham-McDowell
x	VT LTC Ombudsman Project	Kaili Kuiper
	VT Council of Developmental and Mental Health Services	Marie Lallier
x	VCIL	Sarah Launderville
	BIAVT	Jess Leal
x	SASH	Liz Genge
x	VT Association of Adult Day Services	Kristin Bolton
	Alzheimer’s Association	Meg Polye
	OneCare VT	Carrie Wulfman, MD
	COVE	Ruby Baker
x	Caregiver	Jane Dwinell
	Consumer	Pamela Smith
x	UVM Center on Aging	Jeanne Hutchins
x	V4A	Mary Hayden
x	Brain Injury Alliance	Ashley McCormick
	Brain Injury Alliance	Elizabeth Reagle
	AgeWell	Diana French
x	DAIL	Angela Smith-Dieng
	DAIL	Angela McMann
x	DAIL	Megan Tierney - Ward
x	HST	Joshua Slen
x	HST	Heather Johnson
x	HST	Julie Trottier
x	HST	Adriana Boroff

Meeting #4 Follow Up

- Some of the solutions shared in Meeting #4 are worrisome, specifically the suggestion about releasing only half of the MNG funds initially. There is a fear of agencies overspending and so may keep people from receiving services.
- HHAs need to be a part of the decision-making process. Is there going to be an opportunity for HHAs to see recommendations to provide feedback?
  - All notes are available for sharing with HHAs to provide feedback at any time. HST encourages members to share the notes and recommendations with other members of your respective organizations in order to ensure feedback is heard.
  - HST will follow up with DAIL regarding sharing a draft of the report.
- What is the impact of the conflict free case management work going on simultaneously? Will this impact the recommendations or the work of this group? Will it impact how we move forward? There are many things up in the air that impact each other, and we should all remain aware.
  - This workgroup is tasked with providing recommendations to the legislature which may or may not move forward depending on their action. The work of the conflict case management is required in response to CMS feedback to come into compliance and changes will move forward as must come into compliance. The work of this workgroup will be nuanced in light of that work.

Primary Meeting Question: How to proactively identify Vermonters across all payers who have the greatest need for extended supports?

Populations to consider.

- There are hundreds of people who have chronic conditions linked to COVID. How do we access people to provide equal opportunity to programs? We try to let them know their rights around ADA.
- People about to be homeless or released people with no plan.
- Migrant communities: don't understand programs that are out there.
- There are assumptions about parents who are not parenting well.
- People under age of 60 who are brain injury survivors. They feel left out of services. They have executive functioning issues. They are often told to call another organization when they call but they already have difficulties navigating the system. They feel discouraged and build a distrust of the system. It is hard to advocate for yourself with cognitive issues.

Data sources and methods to consider.

- We should consider paying people for their time or offering people something for their time when we're asking them to complete surveys or do screenings. Do a drawing for gift cards. People feel more valued for their time. Also need to be sure everything is accessible (e.g., meeting space, captioning on Zoom, etc.).

- Regarding VITL, we should think about using AI and other ways to take notes and put them into an electronic form to help mine data and identify people that are being served but typically don't have data captured on them.
- We need to remember that when some entities ask these questions in the SDOH screens or assessments, they are not asked in an equitable manner. We need to be sensitive to how and when they are asked.
- Regarding VITL, who can use the data and for whom? We need to think about that when using non-medical data.
- SASH serves 5,000 participants and can be considered an extender of the Community Health Teams. SASH also collects a lot of data on their participants and use a robust assessment.

What data sources are most important to consider for identifying this population?

- Use UVM's network as many people go there and get discharged with something that impacts their brain. Start with medical practices. But how do we get data from them?
- Family practitioners and PCPs. They are an important touchpoint for people.
- Look at community groups and ways to collect data around health. There are strong challenges with how to ask questions. People may not be as honest as they need to be.
- SASH has 5,000 participants around the state with staff embedded onsite so one of the main lines of business is to do an annual wellness assessment that includes about 30 questions. They find that is a strong reason to meet with people and opens conversations. They are not currently connected to VITL, but they could be. Their staff can go into VITL to check for preventative screening results. How can they merge idea to include other partners in VITL? This all needs to be integrated more. We want to share this data in a way that helps people. SASH uses Population Health Logistics (PHL) as their vendor but are now changing to a different vendor with better dashboards. They can pull reports and find that is very useful. The assessment drives their work. They are able to share their data as they have use and disclosure protections in place for their residents. They share data with VNAs, DAs, and AAAs. The question is how can they do this better?
- Data is one thing, but the goal is to identify and talk to people. Who are the people finding the person who needs the services? Would hate the data to get in the way of people actually being served.

Where and how would this data be accessed and used?

- Who would be the collector of the data? How would needs be categorized? Would things be flagged?
- There are new quality metrics required by CMS via the HCBS CAHPS® Survey and there are also quality of life and metrics on quality of life. DAIL is doing some of that through the National Core Indicators and in person surveys of programs. From the HCBS CAHPS® Survey we may be able to learn what is working and not working for people receiving services. This will be starting in the next year or two for VT's five

HCBS services across DAIL and MH. However, it doesn't capture information from people not yet served.

- 211: would help get sense a of whether key needs are but then what do we do with it? It doesn't tell us about people or place.
- Using data to prioritize outreach to those in need is not typically how this data is used. But it can be really helpful when thinking about need and present it to the legislature. For example, a AAA self-neglect workgroup resulted in a report to the legislature that highlighted risk factors that helps to abstractly quantify how many people may be at risk of self-neglect. With outreach and with MNG, we can identify them, but we can't get them services. It is always a struggle with reaching very rural, isolated, high risk people but data isn't a solution to that.
- There are waitlists but there are equity issues. We want to do media outreach to identify who we don't typically reach but then the challenge is the resulting phone calls that come in and we can't always serve them.

What other new strategies, in addition to data sources, can be used to identify this population?

- Vermont has a large number of small towns that know people because the town clerks know a lot. We can reach out to the Racial Justice Alliance, the Migration Justice Alliance. Develop points of outreach.
- AAAs are using a number of these strategies today and the pandemic helped think about how to get this information out. Several years ago, AAAs did a self-neglect awareness campaign where they talked to emergency responders. Referrals nearly tripled as a result.
- There is a huge and well-connected group of service providers that can disseminate information to other marginalized groups or organizations that serve marginalized groups.
- Consider using social media campaigns and get people on TV. Use Facebook and other social media channels.
- What about health plans? Where can we connect with member services departments in managed care plans serving non-aging populations? In other states how does this work get done?
- Designated Agencies (DA's) get a lot of referrals. Can we connect with them to get populations they are seeing most frequently?
- We should think about the overarching goal and early days of MNG and how the original goal was to delay or prevent NH placement/institutionalization. There was going to be money to track and test as a research and demonstration grant, but we didn't get funding. We never really proved whether MNG prevents people from needing care earlier on. Are we still interested in doing this? And how do we measure this? We have a hard time thinking about data when we don't know what to measure. Do we look at hospital admissions or whoever this expansion goes to? Maybe there would be a way to measure this and demonstrate what we're preventing. Are we still on this old MNG goal?

- It would be great to see if this is effective.
- There is probably info around prevention already, like dental health. We should look at quality of life but also living to full potential, like dental care.

Menti Poll #1 Results: How Would You Define "In Greatest Need"? What Does This Mean to You?

- People who are at highest risk of institutionalization
- People who have traditionally been in marginalized groups
- Someone who does not have support from family/friends and have health needs.
- People not connected to traditional programming.
- People who live alone
- People who tell us they have a need and are turned away from multiple organizations.
- People who live in poverty
- Not having basic needs met (STABLE housing, food, medical providers) and not being connected to programs that can help with organization/executive functioning.
- People experiencing social isolation/loneliness.
- Those who make more money to qualify for Medicaid but can't pay for services.
- People who don't qualify for other services.
- Individuals with unmet needs (including unmet ADL/IADL needs, food security, shelter, etc.) who are not eligible for other programs or for whom other programs would not adequately address those needs.
- Those who have caregivers who need a break.
- Individuals who are at risk of losing housing and worsening health if services are not provided.
- People with multiple needs such as mental and physical health
- People who end up in jail instead of getting services
- People who don't know where to go/who to turn to for help.
- Those who don't understand what is being communicated about programming.
- Caregivers who are suffering (health/mental health) issues

Menti Poll #2 Results: Most Important Methods/Strategies for Identifying Vermonters Across All Payers in Greatest Need of Extended Supports

- PCP offices, hospitals, talking with both person who needs care and their caregivers.
- Hairdressers/barbers
- PCP/CHT/SDOH Screens
- Accessing participants in conversation and being available for follow up for them
- Librarians

- List out traditionally underserved areas and develop outreach plan
- Hospital visits/ER visits/PT, OT, other therapy centers
- Senior centers
- Churches
- Local radio/local TV
- Transportation providers
- Town meetings
- "Third space" places

Next Meeting Volunteers

- Jeanne Hutchins
- Kristin Bolton

Meeting #6

DAIL Extending HCBS Working Group
June 26, 2023
Meeting #6 Summary

Attendees:

	Affiliation/Organization	Name
x	NEK Council on Aging	Meg Burmeister
x	Age Well	Erin Roelke
x	VNAs of Vermont	Eric Covey
	Rutland MH Services	Mary Graham-McDowell
x	VT LTC Ombudsman Project	Kaili Kuiper
x	VT Council of Developmental and Mental Health Services	Marie Lallier
x	VCIL	Sarah Launderville
	Brain Injury Alliance	Jess Leal
x	SASH	Liz Genge
x	VT Association of Adult Day Services	Kristin Bolton
x	Alzheimer's Association	Meg Polye
x	OneCare VT	Carrie Wulfman, MD
	COVE	Ruby Baker
	Caregiver	Jane Dwinell
x	Consumer	Pamela Smith
	UVM Center on Aging	Jeanne Hutchins
	V4A	Mary Hayden
	Brain Injury Alliance	Ashley McCormick
x	Brain Injury Alliance	Elizabeth Reagle
	AgeWell	Diana French
x	DAIL	Angela Smith-Dieng
	DAIL	Angela McMann
x	DAIL	Megan Tierney - Ward
x	HST	Joshua Slen
x	HST	Heather Johnson
x	HST	Julie Trottier
	HST	Adriana Boroff

Meeting #5 Follow Up: How to proactively identify Vermonters across all payers who have the greatest need for extended supports.

- Senior Helpline needs to be added as it is a great spot for many people to seek out different services. AAAs receive 1000s of calls every year. AAAs also do a lot of outreach to communities. Every situation is different. Unmet needs are captured by

AAAs and callers can be screened. AAAs know how to get people the assistance they need, to provide a quality system – not just passing people from one place to another. AAAs can screen and use the independent living assessment (ILA) to gather that information.

- For younger persons, do AAAs screen them as not all callers experienced receiving a screening.
- Suggest including open door clinics – free healthcare for people who are uninsured or underinsured.
- Regarding AAAs and survivors of brain injury, BIA is often told AAAs don't know what to do with callers with brain injury. They don't qualify for case management (CM), and they are always falling through the cracks. They are becoming homeless and are in dire need.
- There is still a budget cut that state asked to make to MNG and along with increases in hourly wages for VNAs/homemakers and adult day, it is going to exacerbate this. Wishing the State Plan on Aging didn't include cuts to the MNG budget. What can be done about this? We've done a great job identifying those in need, but how are we going to pay for it?

Primary Meeting Question: How to best support family caregivers, such as through training, respite, home modifications, payments for services and other methods.

What are the current barriers caregivers experience in accessing already available resources?

- Caregiver is challenged if the client doesn't want supports.
- More spousal and adult children support groups are needed outside of work hours/on weekends and not just offered from the Alzheimer's Association.
- When caregivers (CG) do find information, they are so overwhelmed they don't even know from the list of options, what to choose. Can help be provided earlier? They need help navigating what is available and what is possible.
- Resource navigators are finding that with persons with executive functioning challenges recently discharged from the hospital, they are not qualifying for any services yet and there is so much to navigate during this time. People just need someone to check in with them, to help work on goals, list goals, track goals, and include reminders. Check in's mean so much. Maybe what is needed is a more intense navigation and CM.
- For persons with early onset dementia, there are no navigators helping. They need genuine navigators who really know about services who do the check ins and do the follow up vs leaving this responsibility to the person and the CG. They need CM the way that adults with I/DD get. A holistic version of CM that serves the entire family. It is a holistic approach to the entire system.
- Lack of funding to provide support systems that would create this model. In the caregiving area, there is a lack of funding and increasing inflation. No funding

increases eat away at programs. The Trualta program is being implemented by some AAAs and go in as a CG to the program website and they can find a complete array of topics. It is available 24/7, which is so important outside of regular office/business hours. NEKCOA started a year ago and have 90 people signed up already. There is no cost as the AAA pays for it with Older Americans Act funding.

- AAAs also use TCare. It collects data from systems they are using to help focus on the best interventions, but they need more money and human power. TCare helps prioritize interventions based on unique situations. States using data driven systems like this are showing impacts. We need to be more data centered in what we're doing and resources we're using to know where to put resources.
- There are lots of different ways people get access to resources including word of mouth. We need many doors. PCPs, town clerks, ministers, etc. promoting that there are services is important to combat stigma and encourage caregivers to seek help early. Keep messaging to community via many channels.
- Would be great to promote something like "Ten signs you might need CG support" to identify signs of burnout. Such as a PSA announcement. Call this number. Help normalize it.
- The Alzheimer's Association has 10 symptoms of caregiver stress and it is available on their website here: https://www.alz.org/help-support/caregiving/caregiver-health/caregiver-stress and here: https://www.alz.org/help-support/caregiving/caregiver-health/caregiver-stress#symptoms

What are the gaps?

- Assessments are not capturing executive functioning challenges.
- There is a gap between those who can afford care and those who can't and are on Medicaid or another program. In VT there are a lot of people slightly above the limit. We should be looking at things we can do to bridge that gap so people can survive longer in their homes. People are even moving out of state so they can qualify for services.
- We are putting people on the brink of going into bankruptcy and poverty. We have people eligible for MNG but there are huge waitlists.
- Could we think about financial calculators that could project out and based on what you're doing in five years you'll be "here so let's help you use your money this way now".
- We need to raise the asset amount.

What are the most promising strategies and approaches to best support family caregivers?

- Adult day. This program serves both people. It helps the entire system.
- How can we set up blink systems with two way talking so can be at work and still check in on loved one? Use of technology should be explored.
- Behavioral support coaching.

- In CO the Brain Injury Association has tech classes and this is expanding to CG.
- For technology can see positive and negative. Is this going to be culturally competent for people? We need to think about that. How can we connect to people who could still be directing their own services? How hire someone and talk to the CG. How can we work with people as a person with a disability? Sometimes we see that once a person's disability gets to a certain place the CG begins making all the decisions. How can we empower people to still be in the driver's seat?
- Part of supporting the CG is how to get buy in from the client. Migrant populations migration status is variable within a family. Some are reluctant to get help as they are "afraid" as they are not here legally or are afraid in general because of how others have been treated.
- Many other cultures believe in multi-generational families, but many are lost by coming here as families are now broken apart.
- We need to get what's already out there out. We have a lot of low hanging fruit; women circles, go through known channels. We put too much weight on availability of it when a lot of what we're talking about is a human thing. There is concern about artificial intelligence CG. There are ethical considerations.
- For people with dementia using technology is harder to use as the disease progresses.

Menti Poll #1 Results: What are the best methods for supporting family caregivers?

- Start with assessment to really understand needs/goals comprehensively.
- Listening and coaching
- Direct funding, respite, options for people not on Medicaid (middle class, lower middle class), expanding matching of volunteers.
- Paying them for the work they are doing.
- Provide respite resources. Provide stipends directly to caregivers for work they are doing.
- Emotional support
- A person who can listen and create a relationship of support in figuring out with the caregiver their unique needs.
- Provide more flexible funding to pay for respite services (in-home care, adult day, out of home respite, etc.)

Menti Poll #2 Results: Which state and national innovations are of greatest interest?

- I appreciate the presumptive eligibility in programs overall.
- Tax credits
- Paid family leave
- Structured family caregiver Waiver: Hawaii model – support for working caregivers.

- The Hawaii program sounds amazing. Curious how it is funded.
- Many different options: one size doesn’t fit all.
- Some of the programs that offer some financial break to caregivers.
- The creative ways states are working to address gaps between eligibility and need around caregivers. The caregiver tax credit. Letting caregivers leave work be eligible for unemployment benefits.
- Better expansion of eligibility

Next Meeting Volunteers

- Kristin Bolton
- Meg Burmeister
- Ashley McCormich
- Elizabeth Reagle
- Pamela Smith

Meeting #7

DAIL Extending HCBS Working Group
July 17, 2023
Meeting #7 Summary

Attendees:

	Affiliation/Organization	Name
	NEK Council on Aging	Meg Burmeister
x	Age Well	Erin Roelke
x	VNAs of Vermont	Jill Olsen
	Rutland MH Services	Mary Graham-McDowell
x	VT LTC Ombudsman Project	Kaili Kuiper
x	VT Council of Developmental and Mental Health Services	Marie Lallier
	VCIL	Sarah Launderville
x	Brain Injury Alliance	Jess Leal
x	SASH	Liz Genge
x	VT Association of Adult Day Services	Kristin Bolton
x	Alzheimer's Association	Meg Polyte
	OneCare VT	Carrie Wulfman, MD
	COVE	Ruby Baker
x	Caregiver	Jane Dwinell
x	Consumer	Pamela Smith
x	UVM Center on Aging	Jeanne Hutchins
	V4A	Mary Hayden
x	Brain Injury Alliance	Ashley McCormick
x	Brain Injury Alliance	Elizabeth Reagle
	AgeWell	Diana French
x	DAIL	Angela Smith-Dieng
	DAIL	Angela McMann
	DAIL	Megan Tierney - Ward
x	HST	Joshua Slen
x	HST	Heather Johnson
x	HST	Julie Trottier
x	HST	Adriana Boroff

Meeting #6 Follow Up: How to best support family caregivers, such as through training, respite, home modifications, payments for services and other methods.

- Paid family leave would help alleviate some stress for families
- CARERS program – group therapy groups for people care for those with dementia. Also Peer to peer mentor program – matching caregivers who would like a trained peer mentor 1:1. Mostly gives someone to talk with in person or via text, video. UVM is starting a master's level social work program for geriatric in the fall
- Challenges for presumptive eligibility because case management doesn't get paid for.

Primary Meeting Question: The feasibility of extending access to long-term home and community-based services and supports and the impact on existing services.

Is it feasible to extend access to long-term HCBS?

- It's hard to expand services with inconsistent funding stream.
- Waitlists exist now because of staffing issues.
- Re: waitlist, need more capacity for prioritization. Complicated question of needs and how to best allocate resources. Currently home health agencies don't have staff to provide needs.
- In Chittenden County, more than 200 people on waitlist. Adult day is one of the most impactful ways to help people and caregivers both. There are adult days with no waitlist now.
- People's needs can be met by giving any answer, even if its no. Need a better assessment of needs out there.

If feasible, what would that look like? What would a "to be" or "future state" look like?

- A huge gap is someone to check in on people on the waitlist.
- People on MNG waitlist, don't know what they are receiving now. No one is checking. Many die or move away. We check on TBI waitlist to be sure they get resources while they are waiting. Opportunity to have a resource facilitator to help complete application and check on them. Develop pilot programs with people who are homeless, or other populations. Could have a better understanding of people in the state.
- Re: training. Learned we have lots of untapped resources because people don't know about them. E.g., learn how to get to a free Alzheimer's caregivers support group. There are things available not known to people. Real advantages of putting a group of state/regional caregivers together on a zoom call rather than 1:1. If expanding, better to do it in a group re capacity and outcomes.
- A small package of services for those on waitlist might be just case mgmt. We worked with UVM HHH to share resources and helped many people on waitlist. There are different reasons why people are on the waitlist no longer needing services. If we had been providing case mgmt. to them it would have resolved many of their issues (e.g., seeing progression of needs and get them on high CFC, etc.).
- BIA sees a huge need with paperwork and navigating the system.

- Need hands on help with practical logistical stuff, like meal planning.
- A support network that can be connected to light case mgmt. /resource facilitation. We are seeing people who are at home and receiving nothing.
- Making MNG an entitlement program or state plan service.
- Support encouraging immigrants to come and do direct care work that we don't have citizens for now.
- Personal emergency response systems (PERS). Huge demand for that as a standalone service. Cost is $300-500 per year. We spent more than half of flex funds on PERS grants for people. Can fit in nicely in initial package of services along with case mgmt.
- Medic alert bracelet, $80/year so EMS can find all our information.

What would be the impacts on existing services that need to be considered?

- The problems we have now with existing services aren't solved with new services. Let's not use technology to take care of people. Can we use tech within care mgmt. processes to be more efficient? Don't want to spend money that doesn't go to end user. Streamline process so people who need services get the money.
- We are having conversations now re conflict free case mgmt., learning that challenges that may come up is that those with just case mgmt. may have higher needs because they aren't getting any other services.
- Technology is difficult for older people and those with dementia, etc.
- Medicaid administrative billing. Available now? Yes. See resources at the end of these notes.
- Definition of case mgmt. – Should be to follow the person across time, a consistent person. Vs resource navigation.
- Need to define case mgmt. across the board, with AAAs etc. intensive, maybe medical, frequent check ins. We are seeing that is not happening, especially for people with TBI. There is a misunderstanding of who is doing what in the state.
- Overlapping case mgmt. and resource facilitation/ options counseling. When people get a case mgr, we step away.

Menti Poll #1 Results: What are the most important "to be" or "future state" considerations?

- Services that provide support to the most people - adult day for example
- Consider impact on capacity of system to provide services to those already eligible - limited workforce must be considered at all phases
- Initial package of services on eligibility: case management, PERS, and small ADHM flexible fund ($500 or less) - while waiting for more funding or services
- With anticipated increased need, focus on prevention - services that would have the biggest impact, not sure if that's case management, PERS, or other things.
- I think if we can only offer a small package of services, they should be as tailored to the individual as possible. This will both benefit the users and maximize worker availability.

- Resource navigation that is accessible and no rigid guidelines/hour requirements
- Defining case management as there seems to not be clear understanding of what it is
- Case management vs. Resource Facilitation as options
- Navigators for all. Using technology that we became comfortable with during Covid - Care navigators can work from home - open up workforce availability by employing workers who typically cannot go
- Direct help initially for executive function help with organization, applications, resources, apps and associated help to learn apps…then regular check in for stuff as it comes up and ongoing assessments

Menti Poll #2 Results: What are the best "feasible" ideas for extending access to HCBS?

- I think the first step is expanding our ability to understand people's needs and triage accordingly.
- Decouple case management but then have that be comprehensive case management
- Listen/connect to everyone on the waitlist to see what other programs they can explore while on the waitlist so that they don't decline.
- Maybe a recommendation for a statewide assessment of the MNG waiting list, both people on it and the process for managing it.
- Have assessments capture executive function
- Separate case management. Separate funds so that access to life skills and home navigation can occur
- MNG as entitlement / state plan amendment in ways that give stability to the funding so that we don't expand the program and then not have adequate funding
- Executive functions and home life skill supports
- Something for family caregivers
- Assessment of moderate needs list
- Support organizations on getting work permits for immigrants which would also help diversify the workforce
- Manage at state level
- Allow people to be able to purchase case management
- Separate resource navigation from other case management which may cut the number of people on the waitlist. These need to be locally knowledgeable

Next Meeting Volunteers

- Elizabeth Reagle

Resources to Share

Medicaid Administrative Claiming Resources:

- Medicaid No Wrong Door System and Medicaid Administrative Claiming Reimbursement Guidance

- Reference Guide for NWD System Medicaid Administrative Claiming
- NWD Medicaid Administrative Claiming Workbook – a very helpful tool
- Administration for Community Living (ACL) Technical Assistance Community Medicaid Claiming resource webpage.
    - Medicaid Administrative Claiming Infographic
    - Iowa's Medicaid Administrative Claiming Time Tracking Tool
    - NWD Administrative Claiming Webinar Podcast

Meeting #8

DAIL Extending HCBS Working Group
August 21, 2023
Meeting #8 Summary

Attendees:

	Affiliation/Organization	Name
x	NEK Council on Aging	Meg Burmeister
x	Age Well	Erin Roelke
x	VNAs of Vermont	Jill Olsen
x	VNAs of Vermont	Eric Covey
	Rutland MH Services	Mary Graham-McDowell
x	VT LTC Ombudsman Project	Kaili Kuiper
	VT Council of Developmental and Mental Health Services	Marie Lallier
	VCIL	Sarah Launderville
	Brain Injury Alliance	Jess Leal
x	SASH	Liz Genge
x	VT Association of Adult Day Services	Kristin Bolton
x	Alzheimer's Association	Meg Polyte
	OneCare VT	Carrie Wulfman, MD
	COVE	Ruby Baker
x	Caregiver	Jane Dwinell
x	Consumer	Pamela Smith
x	UVM Center on Aging	Jeanne Hutchins
	V4A	Mary Hayden
x	Brain Injury Alliance	Ashley McCormick
x	Brain Injury Alliance	Elizabeth Reagle
	AgeWell	Diana French
x	DAIL	Angela Smith-Dieng
	DAIL	Angela McMann
x	DAIL	Megan Tierney - Ward
	HST	Joshua Slen
x	HST	Heather Johnson
x	HST	Julie Trottier
x	HST	Adriana Boroff

Primary Meeting Question: Potential changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication.

- Possible changes to service delivery?
- High impact, low-cost changes?
- High impact, high-cost changes?

Possible innovations were discussed including a review of the PACE Vermont, Inc. program that was in operation serving dually eligible Vermonters from approximately 2006 – 2013. PACE existed in Burlington and Rutland until 10 years ago. It closed because of funding issues – not an adequate number and sustainable mix of participants with low and high needs, participants needed to change PCPs to the PACE site PCP, unexpected infrastructure costs and repairs, and difficulty finding staff, among other challenges. The workgroup discussed whether PACE should be considered again as a viable option serving dually eligible beneficiaries. Should the workgroup make such a recommendation, this is a change that would require much further exploration, analysis, and input from diverse stakeholders including Medicaid and the healthcare reform team and policy people to be sure there are no conflicts with other policies and plans on the horizon.

Medicare Advantage (MA) strategies to serve dually eligible beneficiaries may not be viable. There are concerns about MA plans in general (although Blue Advantage was stated to be okay), including comments that once a plan draws someone in and they enroll, they are often faced with limited options. The plans are more looking for cost containment and VT doesn't have the volume of people, including the needed mix of high and low risk people. Their provider rates are poor. There was a general comment that MA plans need to do a better job educating the public about what the advantages are of remaining in a FFS plan vs enrolling in a MA plan. Suggestions for a navigator to assist in educating about plan options.
Options available in MA including PACE, Senior Care Options (SCO) and One Care were discussed including a workgroup member who used to work in MA and is familiar with the models sharing they are administered through Aging Services Access Points (ASAPs), which are similar to AAAs in VT. The programs offered are not duplicative and give dually eligible beneficiaries more options.

Ideas for collaborating with OneCare and Blueprint around identification of dually eligible beneficiaries is of interest but there is a question about what actual details OneCare can offer and they don't serve the entire dual eligible population. There will be gaps. If someone isn't attributed to OneCare they won't have data. It was suggested that it could be a place to start-by using common identifiers that are gathered as a result of the ILA and whether those identifiers are similar to data collected by OneCare to identify dual eligible beneficiaries. The Blueprint is identifying the highest cost Medicaid beneficiaries and what their risk factors are that could be helpful in looking at the MNG waitlist and assisting with prioritization. AAAs vary in what they gather and how they use the ILA. At a minimum, common identifiers are DOB, First and Last Name, and address. It was also shared that HHAs also receive the applications for MNG services so there would need to be work to coordinate across all to look at all on the waitlist.
It was noted that there are still incredible workforce challenges but in the last year there have been successes in serving the MNG and waist list people in overcoming these

challenges by using flex funds. The rates paid are better and they've been able to bring people in for in-home services. The big challenges are the way the program is administered, especially the transfers between agencies. One AAA was able to pull 100 people off the waitlist by serving in creative ways. It relieves the pressure from agencies trying to serve the CFC Highest and High needs participants by finding alternative car sources and not competing for resources.
SASH indicated that with a pilot they are implementing there are 105 dually eligible participants in SASH who are members of VT Blue Advantage MA plan. The goal is to reach 150. The traditional housing model is 1300 dually eligible. They are able to assist MA beneficiaries with a variety of things and have received great feedback. They are there to connect the dots for people including social determinants of health and not just medical needs.

Menti Poll #1 Results: What are your biggest concerns about duplication of services?

- Wasting resources that could be better used to benefit recipients.
- What is happening with the HCBS COI - is this program getting integrated with the case management ideas being developed there?
- Potential for wasting time and resources
- Communication between different groups
- We don't have the workforce to afford any duplication.
- There need to be less silos and clearer ways to reduce redundancy
- Confusion from clients about where to best get resources.
- Communication between service providers is key and often lacking.
- That services that sound duplicate but actually are not will be eliminated
- Difficulty gathering data on services needed and provided.
- service providers vying for same participants - conflict between service providers
- The ability to bring the client into the team conversation is often lacking.
- agreement with providers on how not to duplicate--is it always possible? Peoples needs evolve and change
- One care was supposed to help with this but until the client is listened to it can't happen.
- Can you explain what you are planning to do with this information?
- Confusing for clients needing services as to who would be the best provider to serve them

Menti Poll #2 Results: What innovations and potential changes are most important?

- Data on who is eligible for moderate needs
- Collaboration across groups
- more staff
- That we have a clear and consistent means to evaluate need and allow people to tailor their needs not based on budget.
- Is PACE or PACE like services feasible

- Working through the waitlist so that it's not part of our future
- Solutions that do not require more staff - get creative
- That all AAA offer the same services with the same criteria
- more flexible funding/service options to mitigate workforce challenges
- Can ILA's be used more effectively
- Provide services to everyone who needs them. As long as that is not possible, avoid charging patient share to those who are not able to receive services other than case management.
- Ensuring that those with most need are served first.

Report Timeline

- The report timeline was reviewed (included in the slide deck shared for the meeting). It was asked that the specific Monday date be reconsidered to accommodate association meetings and gathering input. HST will review the timeline and suggest an alternate.

Appendix D: Extending HCBS Workgroup Slide Decks

Vermont Extending HCBS Workgroup Meeting #1

January 30, 2023
1:00 – 3:00pm

Agenda

1:00 – 1:10pm	Welcome and Introductions
1:10 – 1:20pm	Review Workgroup Charter
1:20 – 1:30pm	Review Meeting Cadence and Planned Topics
1:30 – 2:00pm	Background and Overview - Where Vermont is today - Moderate Needs Group overview - Other state innovations
2:00 – 2:50pm	Open Discussion
2:50 – 3:00pm	Review Action Steps Wrap Up

Welcome and Introductions

Round Robin Introductions: In the room first followed by virtual participants

Workgroup Charter

Project Vision

Workgroup Purpose

Key Assumptions

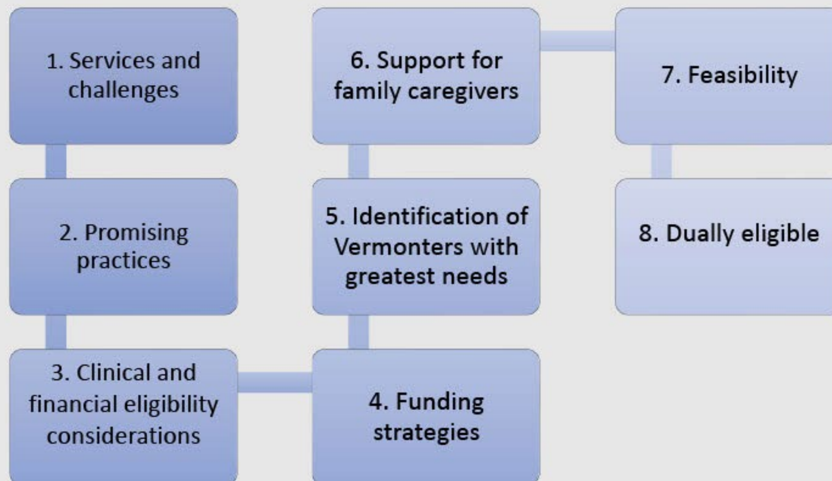
Meeting Ground Rules

Meeting Agenda Format

Topics

Meeting Cadence

Planned Topics



Meeting #1 Questions

What are the barriers to receiving these services?

Which populations are most disenfranchised or experiencing the greatest difficulty in accessing these services?

What are the unique regional or cultural factors that impact Vermonters' ability to access these types of services?

What social determinants of health (SDOH) factors impede access? Why?

Background and Overview: National Facts

- For persons aged 65 and over there is a **68% lifetime probability of needing assistance with at least two Activities of Daily Living (ADLs)** or of developing a cognitive impairment.
- A federal government study estimated that out of pocket HCBS costs from age 65 to death are approximately **$140,000** (in 2015 dollars).
- In 2020, persons age 65+ averaged **$6,668** in out of pocket expenditures, up 38% from 2010.[1]
- In 2020, about **1.1 million** people age 60+ were responsible for the basic needs of at least one grandchild under age 18 living with them.[2]
- In 2020, **45%** of family caregiving was provided by persons ages 45 – 64.[3]

Where Vermont is Today

One of the top four states with the highest percentage of its population age 65+ (21%)

- Estimated number of Medicaid LTSS users per 100 population with an ADL disability
- Nurse delegation and scope of practice
- Transportation policies

- Estimated % of Medicaid aged/disabled LTSS users receiving HCBS

- Number of persons self-directing services for 1,000 persons with disabilities

- Median annual home care private pay costs as a % of median household income for persons ages 65+
- Median annual nursing home private pay cost as a % of median household income for persons ages 65+

Health System Transformation, LLC

Where Vermont is Today: 2021 Legislative Report Recommendations

A limited package of HCBS

- to address nutrition, dehydration, falls prevention, social isolation, medication management, and other needs typically not covered by standard insurance plans.
- designed to improve quality of life, promote health and wellbeing, and stave off the need for more intensive long-term services and supports.

Support for family caregivers

- who help keep their loved ones healthy and at home.

Health System Transformation, LLC

Moderate Needs Group Eligibility

Clinical Eligibility	Services
• Require supervision or any physical assistance three (3) or more times in seven (7) days with any single ADL or IADL, or any combination of ADLs and IADLs. • Impaired judgment or decision-making skills that require general supervision on a daily basis. • Require at least monthly monitoring for a chronic health condition. • Health condition that shall worsen if services are not provided or if services are discontinued.	• Case Management – up to 12 hours per calendar year via the local AAA or Home Health Agency. • Homemaker – up to 6 hours per week via the local Certified Home Health Agency • Adult Day – up to 50 hours per week. • Flexible Funds – Small amount of flexible spending funds through the chosen case management agency.

Health System Transformation, LLC

Where Vermont is Today

Moderate/High/Highest (10/01/2020 – 09/30/2021)

Choices for Care Grouping	Paid Claims	People Served	% of Total
Moderate Needs	$3,861,914	1,032	18%
High and Highest Needs	$214,51,651	4,595	82%
Total	**$218,378,565**	**5,627**	

Vermont offers a limited HCBS benefit to adults ages 18 and over with "Moderate Needs" (MNG).
Participants must meet both financial and clinical eligibility criteria.
The MNG benefit is limited by available funding and serves approximately 1,000 Vermonters at any one time.

Health System Transformation, LLC

Where Vermont is Today

Other State Innovations: Oregon

Five-year 1115 Waiver Demonstration Request

- A gap exists for individuals not yet eligible for Medicaid HCBS, yet who have limited income and are at risk of entering the Medicaid system.
- Some of these individuals receive care from family or unpaid caregivers, while others do not have a caregiver for support with ADLs.

Intention:

- Offer a more robust set of alternative services that can provide a limited, preventative array of services and supports so that a greater number of older adults and younger adults with disabilities can maintain their independence and continue living in their own homes.
- Projecting small savings to Medicaid program at end of 5-year demonstration

Other State Innovations: Oregon

Oregon Project Independence (OPI)

- Provide federal match for existing state-funded OR Project Independence (OPI)
- Began in 1975; State funds and participant fees
- Currently (as of 2019) serves @2,350 older adults and @350 younger adults with disabilities
- Consumers will choose from list of limited supports to help maintain independence (e.g., in-home support/personal care, chore services, adult day, RN services, assistive technology, emergency response systems, home delivered meals, caregiver supports, evidence-based programs, options counseling, transportation, education and training, case management and service coordination)
- No limits on program enrollment

Other State Innovations: Oregon

Family Caregiver Assistance Program (FCAP)

- Launch a new Family Caregiver Assistance Program (FCAP) for older adults and adults ages 18 and over with physical disabilities who are not currently accessing Medicaid programs
- Support consumers whose family embers have chosen to care for their loved ones in their own homes
- Consumers choose from list of services to support and sustain caregiving relationship (same as for OPI)
- Funding capped at $500/month
- Projected 1,800 individuals will be served

Other State Innovations: California, North Carolina

California has an approved 1115 Waiver

- "In Lieu of Services" (ILOS) to address social determinants of health (SDOH)
- On January 4, 2023, CMS issued additional guidance on the ILOS option for states to address unmet HRSN of Medicaid enrollees and clarified 2016 guidance on ILOS for SDOH

North Carolina 1115 Demonstration Waiver

- "Health Opportunities Pilots" testing services that address SDOH including housing, nutrition, and interpersonal violence

Other State Innovations: Massachusetts, Washington

MA Recent 1115 Demonstration Waiver Approval

- Expands Flexible Services Program
- Services include case management and two categories of HRSN
  - Tenancy Preservation Supports
  - Nutrition Sustaining Supports

Washington 1115 Demonstration Waiver

- Tailored Supports for Older Adults (TSOA): for unpaid caregivers and persons without unpaid family support
- New eligibility category and eligibility package for persons ages 55+
- Must be at risk of needing LTSS in future but are not yet financially eligible for Medicaid

Other State Innovations: Arizona, Hawaii

Arizona Family Caregiver Grant Program

- Supports friends and family caring for persons with incomes up to $75,000 (single) or $150,000 (couple)
- Services include information and referral, training, support groups, respite, and home modifications.
- Grants are capped at $1,000 and the administration has requested $325K in their 2023 budget

Hawaii Kupuna Caregivers Program

- For family caregivers working at least 30 hours/week outside the home.
- Provides up to $70/day to support adult day costs, HHA, meal assistance, transportation

Open Discussion

Closing

- Review Action Steps
- Wrap Up

Sources

[1]https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf.

[2]Ibid.

[3]Ibid.

Vermont Extending HCBS Workgroup Meeting #2

February 27, 2023
1:00 – 3:00pm

Agenda

1:00 – 1:10pm	Welcome and Introductions
1:10 – 1:15pm	- Overarching themes from January meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:20pm	- Present topic for discussion and questions for consideration
1:20 – 1:50pm	- Background and overview - Where flexible funding is in Vermont today - Other state innovations - Teams poll (rank flexible services of greatest importance)
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Teams poll (list the most promising opportunities to extend supports to additional Vermonters) - Meeting #3 planning - Review action steps - Wrap up

Welcome and Introductions

Round Robin Welcome:
In the room first followed by virtual participants

Meeting #1 Overarching Themes

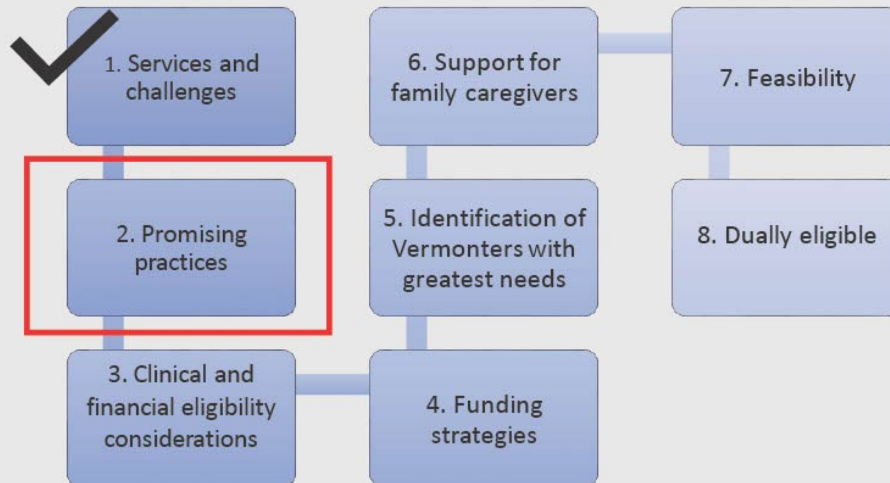
Barriers to Receiving Services	Disenfranchised Populations	Regional/Cultural Factors	Social Determinants of Health
- Affordability - No buy-in/sliding scale options - Services based on Medicaid eligibility vs consumer need - Lack of awareness and knowledge of what's available - Younger populations not eligible - System difficult to navigate - No "one stop shopping"	- Social isolation causes people to remain disconnected from needed services - Limited English proficiency - Stigmatization and fierce independence - Misinformation about the LTC system, such as fears of losing property and savings - Multiple conditions/disabilities, especially a combination of mental and physical health	- Variations in services offered and availability in different parts of the state - Workforce pressures are different, more, or less severe, in different parts of the state - Caregiving is not prioritized in our culture - Vermonters with a 'fierce independence' identity, especially in more rural areas of the state - Rural/urban divide	- Nutrition: services need to accommodate different needs of populations, offer different ways to get food - Housing: retention services needed; avoids being unhoused - Transportation: particularly in rural areas. Key to reducing social isolation and other SDOH gaps - Broadband access: key to connecting to services and unequal across state - PERS: more needed - Flexible funding options

Meeting #1 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

Reminder: Planned Topics



Meeting #2 Topic for Discussion

"The most promising opportunities to extend supports to additional Vermonters, such as expanding the use of flexible funding options that enable beneficiaries and their families to manage their own services and caregivers within a defined budget and allowing case management to be provided to beneficiaries who do not require other services."

Meeting #2 Questions

After analysis, review, and discussion of use of such supports, specifically flexible funds historically – what has worked and what hasn't worked?

What are the direct workforce challenges Vermont is experiencing today (and into the future) and what extended supports could help mitigate these challenges?

What are the lasting COVID-19 and pandemic-facing challenges that should be addressed prospectively?

Background and Overview: Vermont Flexible Funding

- Flexible Funding services are managed and billed through the participant's chosen case management agency.
- Examples of services eligible for purchase through a Flexible Funding budget:
  - Self-hired Attendant (including required use of Intermediary Services Organizations or ISOs)
  - Goods & Services
  - Agency Administrative Fee

Examples of Goods & Services:

- Personal Emergency Response Services (PERS)
- Assistive Devices (e.g., grab bars)

- Home Modifications (e.g., ramp, widened doorways)
- Home goods or appliances that support ADLs/IADLs

- Transportation for non-Medicaid eligible participants
- Interpreter services for non-Medicaid eligible participants
- Personal Care, Respite, Companion Services

Flexible Funding is limited to a budget of $3,500 per person per calendar year.

Where Vermont is Today: Use of Flexible Funding*

- Cleaning
- Personal care
- Adaptive devices: grab bars, shower head/holder, walker
- Medical monitoring
- Home goods/items: freezer, vacuum
- ARIS administrative costs

* Based on one agency.

Historical MNG Flexible Funding Recommendations

DAIL Advisory Board MNG Workgroup Suggested Solutions
March 2018

1. Streamline ARIS and the billing in some way – handle it like the Veteran's program.
2. Need local flexibility to use flex funds regardless of the person's choice of case management agency. Currently, it is the chosen case management agency (HHA or AAA) who uses their flex funds if that is what the person needs. However, if funds are exhausted, the current system requires the person change case management agencies to utilize the flex funds of the other agency.
3. Tie flex funds to people and not organizations – connection of MNG flex funds to person vs. agency (although VNA can't provide a single modality of service.)

Other State Innovations: Massachusetts

MassHealth's Flexible Services Program (FSP)

- Testing whether MassHealth ACOs can reduce the cost of care and improve their members' health outcomes by paying for certain **nutrition and housing supports** through implementing targeted evidence-based programs for certain members.
- Expanded services include case management and two categories of Health-Related Social Needs (HRSN)
  - **Tenancy Preservation Supports**
  - **Nutrition Sustaining Supports**
- ACOs are not required to continue providing FS to members indefinitely
- ACOs need to ensure that their individual FSPs include plans to support the member's needs following FS (e.g., an individual FS program that provides first month's rent for members and then helps members obtain Tenancy Sustaining Supports through other public programs beyond FS)

Other State Innovations: Massachusetts

MassHealth's Flexible Services Program (FSP)

Tenancy Preservation Supports: Include services, goods, and transportation that are aimed at assisting eligible members with finding, transitioning into, preserving, and modifying housing.

Pre-Tenancy Supports: Individual Supports	Pre-Tenancy Supports: Transitional Assistance
- Assessing and documenting member preferences for housing/tenancy - Assisting member with budgeting for tenancy/living expenses, applying for and obtaining benefits or applying for community-based tenancy, obtaining services needed to establish safe and healthy living, assisting or providing transportation to approved supports when needed	- Assisting member with obtaining and/or providing one-time household setup costs and move-in expenses such as first/last month's rent, security deposit, back utilities, utility deposits, household furnishings

Other State Innovations: Massachusetts

MassHealth's Flexible Services Program (FSP)

Tenancy Preservation Supports: Include services, goods, and transportation that are aimed at assisting eligible members with finding, transitioning into, preserving, and modifying housing.

Tenancy Sustaining Supports that assist member with:	Home Modification: limited physical adaptations to ensure health, safety, and welfare
- Communicating with landlord/property manager regarding member's disability and needed accommodations - Reviewing, updating, modifying tenancy supports - Obtaining and maintaining benefits, establishing credit - Tenancy training, lease compliance, household management - Legal advocacy and coaching - Obtaining or improving adaptive skills to function and live independently - Transportation	- Installation of grab bars and hand showers - Doorway modifications - In-home environmental risk assessments - Mold remediation - Refrigerators for medicine (e.g., insulin) - HEPA filters - Vacuums - Pet management supplies and services - A/Cs - Nightlights

Other State Innovations: Massachusetts

MassHealth's Flexible Services Program (FSP)

Nutrition Sustaining Supports: includes goods, transportation, and services that educate members about appropriate nutrition and help members access food needed to meet needs.

Assisting with, obtaining or providing:
- Benefits and credit, completing and filling in applications
- Household supplies needed to meet nutritional and dietary needs including kitchen cleaning and sanitation supplies
- Access to foods that meet nutritional and dietary need that cannot otherwise be obtained through existing programs (e.g., groceries, nutritional vouchers)
- Nutrition education and skills development
- Healthy, well-balanced, home-delivered meals

Other State Innovations: Oregon

Oregon Health Related Services (HRS): non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being

Goals:

- Promote the efficient use of resources and address members' social determinants of health to improve health outcomes
- Alleviate health disparities
- Improve overall community well-being

Includes:

- **Flexible Services** that supplement covered benefits
- **Community Benefit Initiatives** that are not limited to only members and are focused on improving population health and health care quality

Other State Innovations: Oregon

Health-Related Services Examples including those related to SDOH

- **Care coordination, navigation or case management** activities (for example, education for health improvement and management, language and literacy, and higher education);
- **Food services and supports** (for example, vouchers, meal delivery, farmers market in a food desert);
- **Housing services and supports** (for example, temporary housing or shelter, utilities, critical repairs, environmental remediation, including lead);
- **Items for the living environment** to support a particular health condition (for example, items to improve mobility, air conditioner, athletic shoes, other specialized clothing);
- **Transportation** services and supports (for example, transportation for groceries or non-medical appointments related to individual social needs; community level transportation improvements such as bike lanes and walking paths);
- **Trauma-informed services and supports** across sectors (for example, implementing trauma-informed care across sectors);
- Other **non-covered health care system services and improvements** (for example, supports for community oral health services, electronic health record [EHR] meaningful use);
- Other **non-covered social and community health services and supports** (for example, social needs screening and referral, including community resource and referral technology and EHR integration; multi-sector interventions to improve population health; interventions to address other SDOH including employment and built environment improvements); and
- Other **non-covered medical services** (for example, medical services which would otherwise be on above-the-line medical services).

Other State Innovations: Oregon

Oregon Project Independence (OPI): consumers choose from a list of limited supports to help maintain independence

- In-home supports/personal care
- Chore services
- Adult day
- RN services
- Assistive technology
- Emergency response systems
- Home-delivered meals
- Caregiver supports
- Evidence-based programs
- Options counseling
- Transportation
- Education & training
- Case management
- Service coordination

Other State Innovations: California

- CalAIM (California's Medicaid program) will connect Medicaid participants to Community Supports to meet their social needs, including medically supportive foods or housing supports. There are 14 pre-approved Community Supports:

- Housing Transition
- Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization
- Housing Recuperative Care (Medical Respite)
- Day Habilitation Program
- Caregiver Respite Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities

- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Other State Innovations: Arkansas

- **Independent Choices Program**: State plan services under 1915(j). Offers Medicaid-eligible older adults and adults with physical disabilities the opportunity to self-direct personal assistant services including a cash allowance.

- Self-directed Personal Assistance Services: Salary or wages of self-hired personal assistant(s) to provide self-directed Personal Assistance Services
- Backup and Respite Personal Assistance
- Technology for Safety, Communication, and Independence
- Service Animal
- Cost of a complete national fingerprint-based criminal background check on a self-hired personal assistant(s).
- Discretionary Cash used to purchase personal hygiene items for the beneficiary.

With prior written approval:

- Environmental Accessibility Adaptations
- Emergency Goods and Services

Other goods and services on a case-by-case basis:

- Increase the participant's independence and reduce the need for Medicaid-funded paid human assistance
- Can be economically purchased and reliably provided
- Will not result in funds in the individual's IndependentChoices budget being insufficient to meet the participant's needs

Direct Care Workforce

Challenges

DAIL SFY23 Budget Testimony: MNG as of July 2021 had 1,085 people enrolled, an **8% decrease**. The reduction in enrollments primarily attributed to Homemaker Services **due to workforce demands.**

Innovations

- **VT ARPA Section 9817 Plan:** Promote High-Performing and Stable Workforce via Training and Recruitment and Retention
- **Other state approaches:** Training, Wages and Benefits, Recruitment and Retention, Paying Family Caregivers

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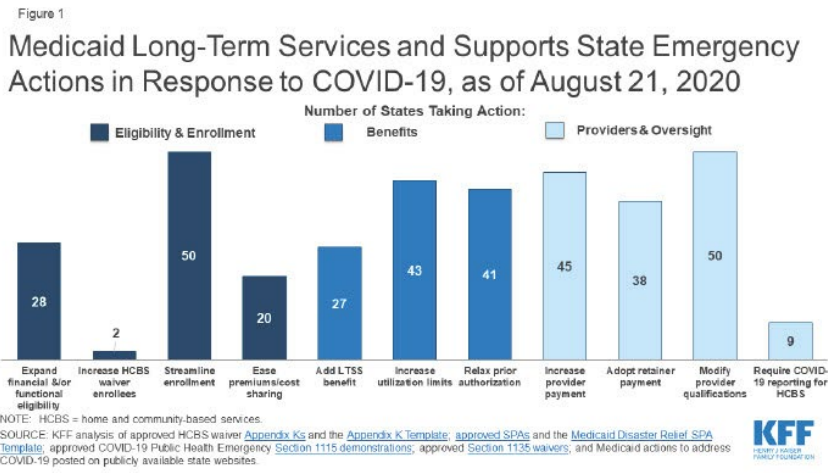
COVID-19 Challenges and Innovations



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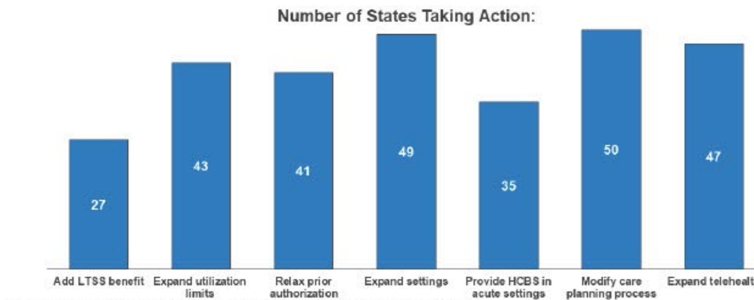
COVID-19 Challenges and Innovations

Figure 3

Medicaid LTSS Benefits State Emergency Actions to Address COVID-19, as of August 21, 2020



NOTES: LTSS = long-term services and supports. HCBS = home and community-based services.

SOURCE: KFF analysis of approved Appendix Ks and the Appendix K Template; approved SPAs and the Medicaid Disaster Relief SPA Template; approved COVID-19 Public Health Emergency Section 1115(a) demonstrations; approved Section 1135 waivers; and Medicaid actions to address COVID-19 posted on publicly available state websites.

Other Approaches to Flexible Funding and Service Expansion via ARPA Section 9817 Plans

Vermont

- Vermont plans to use $10,000,000 for initiatives that promote health equity and reduce health disparities experienced by people with HCBS needs. The State will award grants to providers seeking to test the use of flexible funding to address health-related social needs. These opportunities will allow providers to address issues identified in their communities and develop partnerships with community-based organizations
- As identified in the Behavioral Risk Factor Surveillance System 2018 report, Vermont adults with a disability are eight times more likely to report fair or poor health than adults with no disability, a statistically significant difference. Vermont will reduce this health disparity by awarding grants to providers and community-based organizations to develop and provide health and wellness programs for individuals with HCBS needs.

Other Approaches to Flexible Funding and Service Expansion via ARPA Section 9817 Plans

Enabling Technologies

- **California:** $50 million to find Access to Technology Program for Older Adults and Adults with Disabilities Pilot: provide grants directly to county human services agencies to help reduce social isolation, increase connections, enhance self-confidence
- **North Carolina:** Purchasing technology such as laptops, cell phones, other technology to facilitate socialization
- **Alabama:** Enhancing broadband to provide access to virtual services including telehealth
- **Delaware:** Implementing remote monitoring services that will also strengthen the DSP workforce for those who could be safely managed without in-person support and providing computer tablets to participants who are homebound to support community integration and ability to access telehealth
- **Iowa:** One-time grants to purchase technology and equipment to support the direct delivery of HCBS. Remote Support allows an off-site direct service provider to monitor and respond to a person's health, safety, and other needs using live communication, while offering the person more independence in their home.

Teams Poll

Rank flexible services of greatest importance

Please rank the services in the Teams poll.

Open Discussion

After analysis, review, and discussion of use of such supports, specifically flexible funds historically – what has worked and what hasn't worked?

What are the direct workforce challenges Vermont is experiencing today (and into the future) and what extended supports could help mitigate these challenges?

What are the lasting COVID-19 and pandemic-facing challenges that should be addressed prospectively?

Teams Poll

List the most promising opportunities to extend supports to additional Vermonters

Please write your responses in the Teams poll.

Meeting #3 Planning

Topic: How to set clinical and financial eligibility criteria for the extended supports, including ways to avoid requiring applicants to spend down their assets in order to qualify.

Are there any necessary changes to current clinical eligibility criteria to support a broader cohort of Vermonters?

Are there any additional factors to consider (e.g., creative alignment of criteria) that supports an expanded population? Any unique criteria for specialized populations?

Are there financial eligibility criteria that promotes or lacks protection for Vermonters to spend down in order to qualify for services? Are there any adjustments that should be made to accommodate the current fiscal and economic reality?

Meeting #3 Planning

Approach

- Identify small group of interested and knowledgeable members who would like to prepare for our next meeting and share ideas and thoughts.

Interested parties?

- Please raise your hand or let us know if you'd like us to follow up with you.

Closing

- Review Action Steps
- Wrap Up – May meeting date poll

Sources

- **MassHealth's Flexible Services Program (FSP)**: download (mass.gov)
- **Oregon Health Related Services (HRS):**OHA-Health-Related-Services-Brief.pdf (oregon.gov)
- **California:** Enhanced Care Management and Community Supports (ILOS)
- **Arkansas:** IndependentChoices - Arkansas Department of Human Services

Vermont Extending HCBS Workgroup Meeting #3

March 20, 2023
1:00 – 3:00pm

Agenda

1:00 – 1:05pm	Welcome and Introductions
1:05 – 1:15pm	- Overarching themes from February meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:35pm	- Present topic for discussion and questions for consideration - Present framing questions and ideas for discussion
1:35 – 1:50pm	- Background and overview - Current and future VT MNG eligibility criteria - Current VT eligibility criteria for other related programs - Other state innovations - Menti poll: Rank state innovation strategies of greatest importance or for consideration
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Menti poll: Share the most important clinical and financial eligibility ideas for the report - Meeting #4 planning - Review action steps - Wrap up

Welcome and Introductions

Round Robin Welcome: Please write your name in the chat!

Meeting #2 Overarching Themes

What's Worked, What Hasn't Worked

- **Low asset thresholds and long wait lists** continue to be barriers to accessing MNG.
- **Transportation**, and the types of, continue to be a huge challenge, particularly in rural areas.
- Even though there are improvements in managing flexible funds, the **administrative process is still burdensome.**
- Need to consider **alternate strategies** for managing funds.
- Need to consider **prioritization** of the MNG wait list.

Direct Workforce Challenges

- Flexible funds are helping with the workforce challenge.
- This workgroup should consider recommendations for supports that do not pull on the existing and already strained workforce.
- Housing, including availability and affordability, impact workforce pool.
- Hourly rate impacting workforce pool.
- Concerns about expanding HCBS services when cannot currently provide enough direct workforce for existing MNG clients.

COVID-19 Lasting Challenges

- COVID is not gone and will not be gone for some time, if ever. We need to include that in the report.
- Emotional health, mental health, wellness, and prevention: how can flexible funds assist while reducing social isolation?
- Look at what we've been able to do during pandemic and what may be sunsetting that should be sustained. Now is the time to think outside the box.

Overarching theme: Expand flexible funding.

Meeting #2 Flexible Funding Ranking Results

Flexible Funding Priority Ranking

1. Personal care, respite, companion services, homemaker.
2. Transportation (for medical or non-medical purposes).
3. Defined budget to use flexibly.
4. Technologies that support individuals with ADLs/IADLs.
5. Home modifications or other adaptations.
6. Transition or sustainable housing services and supports.
7. Nutritional supports or home delivered meals.
8. Purchasing home goods or appliances.

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Meeting #2 Flexible Funding Additional Ideas

Other Flexible Funding Suggestions

1. Pay caregivers.
2. Communication access and expansion of ASL interpreter services.
3. Communication and broadband access challenges, phone reimbursement for people to access social opportunities, telehealth options that would allow for video.
4. Service animals.
5. Emotional health, mental health, wellness, and prevention.
6. Things that are preventive such as healthy foods, exercise, healthy checkups.
7. Supports that are not pulling on the existing workforce like PERS. Expand PERS to more people.
8. Fund medical alert bracelets and the engraving costs.
9. Expand services like reminder calls for taking medications that eliminate the need for someone to come to their home.

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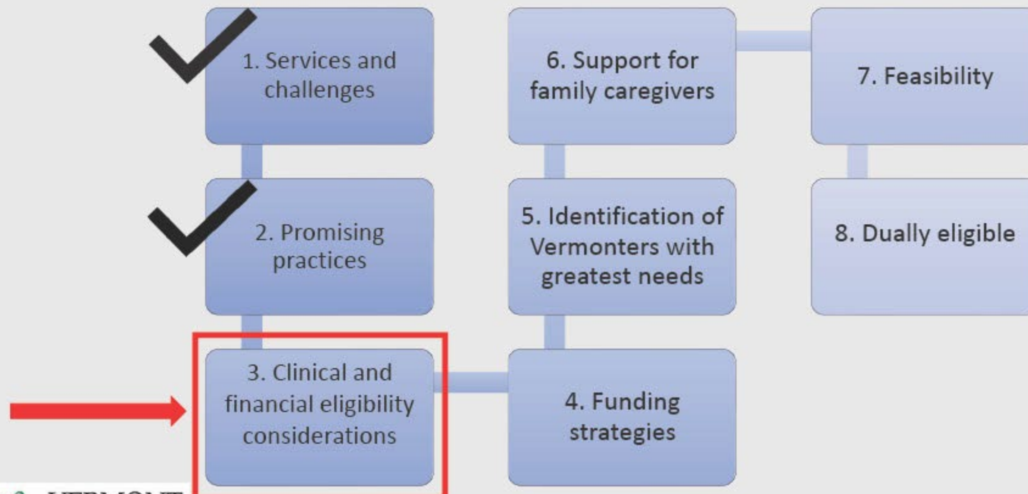
Meeting #2 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

Reminder: Planned Topics



Meeting #3 Topic for Discussion

"How to set clinical and financial eligibility criteria for the extended supports, including ways to avoid requiring applicants to spend down their assets in order to qualify."

Meeting #3 Questions for Consideration

Are there any necessary changes to current clinical eligibility criteria to support a broader cohort of Vermonters?

Are there any additional factors to consider (e.g., creative alignment of criteria) that supports an expanded population? Any unique criteria for specialized populations?

Are there current financial eligibility criteria that promotes or lacks protection for Vermonters to spend down in order to qualify for services? Are there any adjustments that should be made to accommodate the current fiscal and economic reality?

Background and Overview: Eligibility

Moderate Needs Group

Dementia Respite Grants

Attendant Services Program

Older Americans Act Programs and Services

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Moderate Needs Group Eligibility

Current Clinical Eligibility	Future* Clinical Eligibility
• Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADLs.	• Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADLs.
• Chronic condition that requires monitoring at least monthly.	• ~~Chronic condition that requires monitoring at least monthly.~~
• Impaired judgment or decision-making skills that require general supervision on a daily basis.	• Impaired judgment or decision-making skills that require general supervision on a daily basis.
• Worsening health condition without services.	• Health and welfare at imminent risk without services or health condition would worsen without services.

* Effective upon expiration of ARPA Section 9817 maintenance of effort (MOE) requirements.

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Moderate Needs Group Eligibility

Financial Eligibility

*Recurring expenses include medical expenses such as prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-pays, medical equipment and supplies, and other out of pocket medical expenses

Income

Below 300% SSI Federal Payment Rate for one person (or couple) in the community.

Income adjusted after deducting recurring expenses*

Countable income includes Social Security, SSI, retirement, pension, interest, VA benefits, wages, salaries, earnings and rental income, whether earned or unearned

Resources

Below $10,000.

Individuals with income below 300% FBR but have excess resources > $10,000 may apply resources up to limit

Countable resources include cash, savings, checking, certificates of deposit, money markets, stocks, bonds, trusts, or other liquid assets**

**Excluding primary residence or one car, that an individual (or couple) owns and could easily convert to cash to be used for his or her support and maintenance, even if the conversion results in the resource having a discounted value. A $10,000 disregard is applied as an adjustment to resource limits

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Historical MNG Eligibility Recommendations

1. Use **acuity of need vs chronology** to determine entrance into the program from the wait list.
2. Consider **financial and/or eligibility screening** to get onto the waiting list to ensure a more accurate representation of need.
3. **Codify consistent rules** for the wait list.
4. Current MNG clinical eligibility criteria are **too broad**.

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Vermont Dementia Respite Grant Eligibility

Be living at home (not in skilled nursing or in a residential care home).

Diagnosed with Alzheimer's, Frontotemporal dementia, or other irreversible and progressive memory disorder.

Single: **monthly income not exceeding $3,398** (approximately $40,770/year).

Couple: **monthly income not exceeding $4,578** (approximately $54,930/year).

Not eligible for or [illegible]ing services from Choices for [illegible] [illegible]terans Independence Program, Attendant Services Program, or National Family Caregiver respite programs.

Attendant Services Program Eligibility

- **Personal Care Services:**
  - Have a disability
  - Eligible for community Medicaid
  - Need assistance with at least 1 ADL or meal prep
- **Group Directed Attendant Care Services:**
  - Have a permanent and severe disability
  - Need assistance with at least 2 ADLs
  - Need no fewer than 4 hours of assistance daily
  - Live as part of a group of eligible individuals in a group living situation, approved by the Department
  - Capable of own services
  - Ineligible for any other Medicaid or state-funded programs
- **Participant-Directed Attendant Care:**
  - Have a permanent or severe disability
  - Need assistance with at least 2 ADLs
  - Capable of directing own services
  - Ineligible for any other Medicaid or state-funded program
- **Medicaid Participant-Directed Attendant Services:**
  - Have a permanent or severe disability
  - Need assistance with at least 2 ADLs
  - Capable of directing own services
  - Eligible for community Medicaid
  - Be willing and able to employ attendants other than spouse or civil union partner

Older Americans Act Programs and Services

Older Americans Act Programs are available to Vermonters aged 60 and over. There is no cost to the consumer for these services. AAAs are allowed to receive voluntary contributions to the cost of services.

Older Americans Act Services

- Information, Referral, & Assistance
- Outreach
- Supportive Services
- Service Coordination
- Case Management
- Nutrition Services (e.g., Home Delivered Meals, Congregate Meals, Nutrition Counseling)
- Health Promotion Disease Prevention Programs
- Family Caregiver Support
- Elder Rights and Protections (e.g., Elder Abuse Prevention Services)

In addition to OAA funding, DAIL manages State General Funds provided to AAAs to supplement the OAA funds for services:

- Volunteer Outreach Funds
- Nutrition Service & Home Delivered Meals
- Alzheimer's Fund
- LTC Flex Funds
- Special Services Fund
- 3SquaresVT (DCF)
- Elder Care Clinician (DMH)

State Innovation Strategies

- Authorizing benefits during a presumptive eligibility period
- Accepting self-attestation as verification for financial eligibility
- Expanding financial eligibility rules
- Serving new populations by expanding financial and/or clinical/functional eligibility rules
- Offering new services
- Strategies to prevent impoverishment
  - Personal allowances
  - Income disregards
  - Special “trusts” (e.g., Miller trusts)

Menti Poll

Please go to www.menti.com and use the code 6888 4105

Write in clinical and financial eligibility strategies of greatest importance

Please input the strategies in the Menti poll.

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Other State Innovations: New Jersey

- New Jersey's 1115 waiver eliminates state review and instead accepts self-attestation of no asset transfers during the five-year look-back period for applicants below 100% FPL seeking LTC and HCBS.
- New Jersey conducted electronic asset verification of randomly selected applications in 2015 and 2016 and found a 0% error rate on these sampled self-attestations, concluding that "the often burdensome five-year lookback process can be safely eliminated for many low-income applicants."

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Other State Innovations: Washington

- Washington's Medicaid Alternative Care (MAC) Program and Tailored Supports for Older Adults (TSOA) provide supportive services to unpaid primary caregivers of older adults aged 55 and over
- Must be Medicaid eligible and meet nursing facility level of care but are not accessing Medicaid LTSS services
- There is no estate recovery
- Provides free services such as:
  - Housekeeping and errands
  - Support Groups and Counseling
  - Specialized medical equipment and supplies
  - Respite care/personal care
  - Training opportunities
  - Adult Day Care

Other State Innovations: Arkansas

- **Personal Care Services/Independent Choices Program Clinical Eligibility**

- Must require "hands-on assistance" with at least 1 ADL
- The definition of "hands-on assistance" is the individual would not be able to perform or complete the ADL three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.
- While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized.
- May not be inpatient or a resident of any of the following:
  - Hospital, nursing facility, Level II assisted living facility, intermediate care facility for ICF/IDD or institute for mental disease (IMD)

Open Discussion

- Framing Questions 1-3
- Other Ideas and Suggestions

Open Discussion: Question #1

Are there any necessary changes to current clinical eligibility criteria to support a broader cohort of Vermonters?

Open Discussion: Question #2

Are there any additional factors to consider (e.g., creative alignment of criteria) that supports an expanded population? Any unique criteria for specialized populations?

Open Discussion: Question #3

Are there current financial eligibility criteria that promotes or lacks protection for Vermonters to spend down in order to qualify for services? Are there any adjustments that should be made to accommodate the current fiscal and economic reality?

Menti Poll

Please go to www.menti.com and use the code 6888 4105

Please write your responses in the Menti poll.

Please share the most important eligibility considerations you'd like to see included in the report.

Meeting #4 Planning

Topic: How to fund the extended supports, including identifying the options with the greatest potential for federal financial participation

How should we prioritize ideas and recommendations?

What research on other state best practices and innovation is most compelling?

Meeting #4 Planning

Approach

- Identify small group of interested and knowledgeable members who would like to prepare for our next meeting and share ideas and thoughts.

Interested parties?

- Please raise your hand or let us know if you'd like us to follow up with you.

Closing

- Review Action Steps
- Wrap Up

Sources

- **New Jersey:** https://www.cshp.rutgers.edu/Downloads/11510.pdf
- **Washington:** https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transf-cms-approved-interim-evaluation-report.pdf
- **Arkansas:** IndependentChoices - Arkansas Department of Human Services

Vermont Extending HCBS Workgroup Meeting #4

April 17, 2023

1:00 – 3:00pm

Agenda

1:00 – 1:05pm	Welcome and Introductions
1:05 – 1:15pm	- Overarching themes from March meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:35pm	- Present topic for discussion and questions for consideration - Present challenges and barriers for discussion
1:35 – 1:50pm	- State funding innovations - Opportunities for consideration - Menti poll: Which funding innovations are of greatest interest? Select your top three.
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Menti poll: Please share the most important funding challenge and possible solution to address in the report - Meeting #5 planning - Review action steps - Wrap up

Welcome and Introductions

Round Robin Welcome: Please write your name in the chat!

Meeting #3 Overarching Themes

Changes to Current Clinical Eligibility

- Currently too broad. Most people would meet criteria.
- Need to consider prioritization and criteria that would be used to prioritize the wait list.
- Dementia Respite Grant criteria limiting due to requirement for formal diagnosis.
- Include self-neglect population.
- Consider factoring in criteria that addresses SDOH, unmet needs, and mental health diagnoses.

Additional Factors and Specialized Populations

- Early onset dementia populations face additional challenges due to often being in middle class or have spouses still working.
- Other younger populations impacted by acute events that turn into long-term functional limitations (e.g., stroke, TBI) that are not eligible.
- Self-neglect populations over and under age 60; need to develop specialized criteria.
- Consider needs of both recipient and caregiver.

Changes to Current Financial Eligibility

- Spousal income disregard too low. Consider modeling on LTC Medicaid (e.g., $140K+).
- $10,000 resource cap is too low; raise to amount that doesn't cause person and spouse to deplete resources.
- Factor in other disregards such as IRAs, 401ks, and 529 plans, housing costs, multi-generational factors and financial responsibilities.
- Allow for cost sharing for MNG/buy-in options.

Menti Poll Results: Clinical and Financial Strategies of Greatest Importance

- Higher spousal disregard. Use LTC Medicaid, at least $140K+
- Add income disregards:
  - Housing costs/related expenses/rent
  - Multigenerational factors
  - IRAs/401ks/529 plans
- Waive financial eligibility for clients who are clinically eligibility and have been determined to be self-neglecting
- Self-attestation presumptive eligibility
- Remove financial eligibility criteria for Dementia Respite Grant due to the known financial impact that caregiving has on family caregivers
- Raise asset limit to $60,000
- Create MNG homemaker program to be administered through a designated MH agency for clients served by those agencies

Menti Poll Results: Important Considerations for Report

- Increase $10,000 disregard for couples
- Same as LTC eligibility for disregard
- Regarding assets, consider excluding savings like IRAs, 401ks, 529s
- Consider risk of hospitalization, excluding more savings
- Other spousal custodial arrangements such as child support, alimony, and putting money into IRAs/retirement
- Disregard $140,000 similar to LT Medicaid for the spouse
- Special eligibility criteria for clients determined to be self-neglect
- Eligibility that considers the needs of both care recipient and caregiver
- Expand clinical diagnosis eligibility to include those such as MCI, mental health problems such as bipolar, perhaps post CVA impairments
- Incorporate social isolation and unmet needs into clinical eligibility and/or prioritization
- Similar to CFC high/highest, consider having DAIL assess clinical eligibility for MNG instead of relying on case management agencies

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Meeting #3 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

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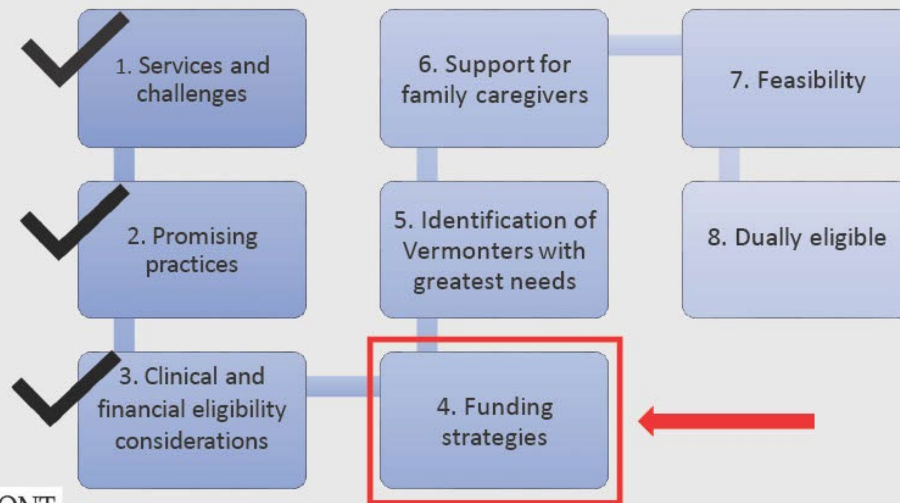
Reminder: Planned Topics



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Meeting # Topic for Discussion

"What are the current challenges with funding, and what are the opportunities for change?"

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Meeting #4 Questions for Consideration

What are the biggest challenges and barriers of existing funding vehicles?

What are the most promising strategies and approaches to overcome these barriers and challenges?

What funding innovations are of greatest interest for further exploration?

Current Funding Challenges and Barriers

1. Funding administration and operations
   - Allocation strategy
   - Timeline
   - Regional differences
   - Population differences
2. Workforce (noted, but will not be focus of discussion)
3. Requirements for self-direction
4. Waitlist operations
5. Services

Meeting #4 Workgroup Member Insights

Operational Challenges

Challenges from a person-centered perspective

Why challenges need to be discussed first

Funding Innovations: Special Supplementary Benefits for the Chronically Ill (SSBCI)

- Created through the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act as part of Bipartisan Budget Act of 2018
- Introduced significant flexibility for Medicare Advantage (MA) plans to offer supplemental benefits that are non-primarily health-related in nature for the first time. The benefits can also be offered in a targeted manner to support an individual's specific needs
- To be eligible, a person must be on Medicare and enrolled in a MA plan and "have a *reasonable* expectation of improving or maintaining the health or overall function of the chronically ill enrollee".

These are non-primarily health-related services:

- Food and produce
- Meals (beyond limited basis) (can be congregate or home-based)
- Pest control
- Transportation for non-medical needs
- Indoor air quality equipment and services
- Social needs benefit (e.g., non-fitness club memberships, community/social parks, park passes, access to companion care, marital counseling, family counseling, classes/programs to improve isolation, emotional and/or cognitive function)
- Services supporting self-direction (e.g., help establish decision-making authority via DPOW, education on financial literacy, technology, language, interpreter services)
- Structural home modifications
- General supports for living (e.g., plan sponsored housing consultations, subsidies for rent or assisted living, gas, electric, water utilities)
- Other

Funding Innovations: Washington Care Act Fund

- Benefits available SFY 2026
- Application for benefits must be filed and person must require assistance with at least 3 ADLs, which is assessed by a qualified assessor via contract
- Benefit unit is payable to a registered LTSS provider
- Qualified family members may be paid for approved personal care services
- An alternative funding mechanism for long-term care access in Washington state could relieve hardship on families and lessen the burden of Medicaid on the state budget.
- The average aging and long-term supports administration Medicaid consumer utilizes ninety-six hours of care per month.
- To be eligible to receive benefits, you must need assistance or supervision with at least three activities of daily living,

Vermont Potential Innovations

- Expand services beyond what is already available?
- Place all into flexible funds?
- Allocation population based but if funds not used transfer funds to higher need areas?
- Use HHA formula in similar way as AAA formula and criteria (e.g., living alone, etc.)?
- Put first half of funds out for use and see how they are spent and then based on use, distribute second half?
- Prioritize wait list statewide?

Menti Poll

Please go to www.menti.com and use the code 3980 0648

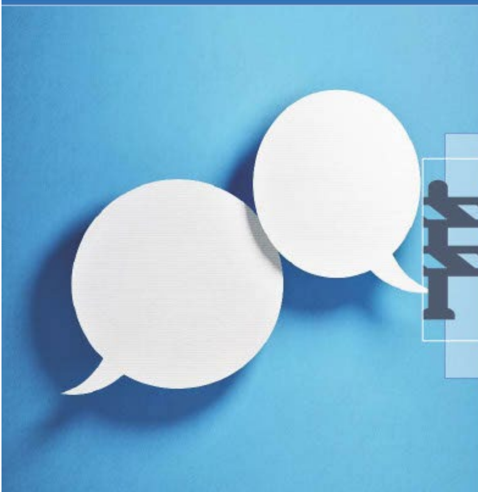
Which funding innovations are of greatest interest? Select your top three.

Please input the strategies in the Menti poll.

Open Discussion

- Framing Questions 1-3
- Other Ideas and Suggestions

Open Discussion: Question #1



What are the biggest challenges and barriers of existing funding vehicles?

Open Discussion: Question #2

What are the most promising strategies and approaches to overcome these barriers and challenges?

Open Discussion: Question #3

Why challenges need to be discussed first

Health System Transformation, LLC

Menti Poll

Please go to www.menti.com and use the code 3980 0648

Please write your responses in the Menti poll.

Please share the most important funding challenge and possible solution to address in the report

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Meeting #5 Planning

Topic: How to proactively identify Vermonters across all payers who have the greatest need for extended supports

How should DAIL capitalize on Vermont's highly integrated and aligned health information systems to elicit required data to support recommendations?

What other sources of data or systems exist to help identify Vermonters with the greatest need for extended supports?

Where and how would this data be accessed and used?

Meeting #5 Planning

Approach

- Identify small group of interested and knowledgeable members who would like to prepare for our next meeting and share ideas and thoughts.

Interested parties?

- Please raise your hand or let us know if you'd like us to follow up with you.

Closing

- Review Action Steps
- Wrap Up

Sources

- Special Supplementary Benefits for the Chronically Ill (SSBCI) Letter
- LTQA & ATI Advisory: Data Brief on SSBCI in Plan Year 2021
- Washington Cares Fund

Vermont Extending HCBS Workgroup Meeting #5

May 22, 2023

1:00 – 3:00pm

Agenda

Time	Item
1:00 – 1:05pm	Welcome and Introductions
1:05 – 1:15pm	- Overarching themes from April meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:30pm	- Present topic for discussion and questions for consideration - Present challenges and barriers for discussion
1:30 – 1:50pm	- Identifying Vermonters across all payers who have the greatest need for extended supports - Opportunities for consideration - Menti poll: How would you define "in greatest need"?
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Menti poll: What are the most important methods/strategies for identifying Vermonters across all payers in greatest need of extended supports? - Meeting #6 planning - Review action steps - Wrap up

Welcome and Introductions

Round Robin Welcome: Please write your name in the chat!

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Meeting #4 Overarching Themes

Challenges and Barriers of Existing Funding Vehicles

- **Operational challenges:**
  - Process of transferring funds and long timeline.
  - Budgeting processes used by agencies leave funds on table.
  - Chronological wait lists.
  - Reporting requirements are laborious.
  - MNG not an entitlement like Highest and High Need or CRT.
  - Current assessment tools do not help identify populations in greatest need, or, that are falling through the cracks (e.g., early-onset Alzheimer's/dementia and TBI)
- **Staffing challenges:**
  - Staff are not paid enough. Compounds worker shortage.

Most Promising Strategies and Approaches to Overcome Barriers

- **Operational changes:**
  - Have fewer entities manage the funding rather than have it spread out – centralize operations.
  - Consider having 'pass through' orgs rather than holders of the funds.
  - Try to build capacity of service availability statewide to reduce variation and service gaps.
- **Funding changes:**
  - More direct avenue of giving money to people like 3Squares, allowing consumers to purchase what they need almost prospectively.
  - If funding left over, raise reimbursement rate to direct services in order to increase pool of workers given worker shortage. Pay a living wage.
  - Increase flexibility in using funds and promote. Hire friends and family. Not everyone needs trained caregivers to go shopping or clean a house.

Funding Innovations of Greatest Interest for Exploration

- Expand case management for more individuals and decouple requirement for case management to be provided with a service.
- Allow for more flexibility to hire case managers if agencies don't have staffing to do it, possibly through passing through of flex funds. There are CMs that may be interested in a few hours a week outside their agency jobs.
- Explore how to include persons with executive functioning needs which are not ADL needs but impact people's daily lives.
- Develop tools that adequately include assessing the needs of persons with executive functioning challenges, regardless of diagnosis or lack of diagnosis.
- Use data to adequately address vacancy rates and the size of the waitlist.

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Menti Poll Results: Which funding innovations are of greatest interest?

1. Place all into flexible funds
2. Prioritize wait list statewide
3. Transfer funds to higher need areas if funds not used
4. Expand services beyond what is already available
5. Place half of funds out for use and see how are spent and based on use, distribute the balance
6. Revisit VT Trust Fund idea
7. Engage health plans | ACOs in alternative funding strategies for non-Medicaid eligible
8. Use HHA formula in similar way as AAA formula and same criteria (e.g., living alone, etc.)

Menti Poll Results: Funding Challenges and Solutions

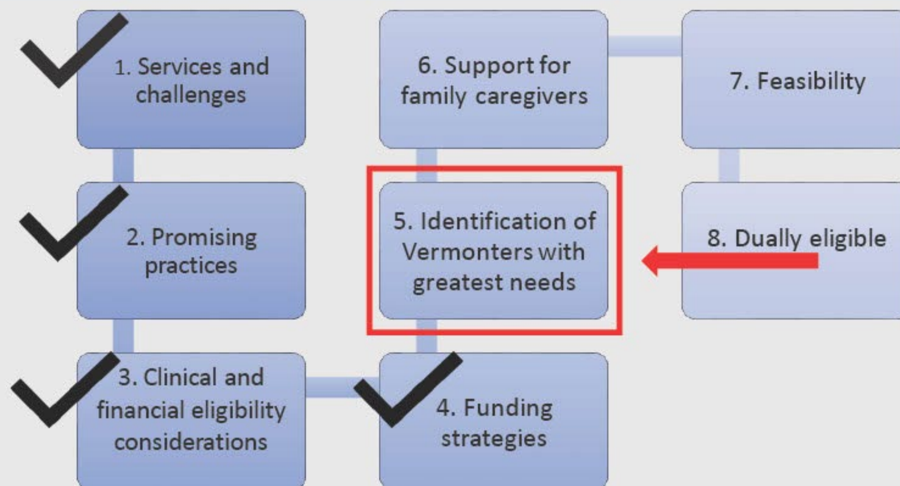
- Access to case management for people not eligible for LTC Medicaid. Can we decouple case management and services requirements?
- Getting case management --decouple or let us use flex funds to hire.
- Create an easy way for consumers to hire. There used to be a previous database of caregivers, but it needs advertising .
- Funding is inadequate for all entities in the LTC system. We need consistent funding that covers costs and is routinely updated. No easy answers.
- Need adequate funding, period. Across the board. Better pay for staff, a living wage. No idea how to do that.
- Better pay for staff.
- Flexible funding that creates a more nimble distribution of funds.
- More funding for flex funds.
- The biggest challenge is inadequate staffing. Spending flexibility may help.
- Help us get background checks for private hire.
- Financial eligibility - e.g., respite grants - separate funds for respite for all caregivers.
- Allow for realization that if you hire, a fair amount of the budget is used up for ARIS.
- Not all HHAs are willing to collaborate regarding unused funding, longer waitlists between AAA and HH. If able to collaborate more clients receive services/less waitlist.
- Anything to reduce administrative costs.

Meeting #4 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

Reminder: Planned Topics



Meeting # 5 Topic for Discussion

"How to proactively identify Vermonters across all payers who have the greatest need for extended supports."

Meeting #5 Questions for Consideration

How do we define "in greatest need"? What does this mean to you?

What data sources are most important to consider for identifying this population?

Where and how would this data be accessed and used?

What other new strategies, in addition to data sources, can be used to identify this population?

Meeting #5 Workgroup Member Insights

Populations to Consider

Data Sources and Methods to Consider

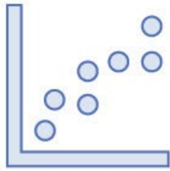
Other Considerations

Member and Other Vermont Stakeholder Perspectives

Populations to Consider

- Long COVID – is going to be a growing number; we need to be prepared
- Unhoused; homeless
- Immigrant; limited English proficiency; cultural barriers
- Undiagnosed yet functionally or cognitively impaired
- Moderate dementia/early-onset dementia or persons with executive functioning challenges

Member and Other Vermont Stakeholder Perspectives



Data Sources and Methods to Consider

- Update assessments/screens to capture populations in greatest need
- Police departments and crisis centers
- Community Health Teams; community nurses/town nurses; paramedics
- Emergency rooms
- Connect data together so can be used – not everyone has access when it is needed
- Build capacity to categorize need or risk, like population health strategies: low, medium, high. Need to drill down deeper. Need to use data sources like VITL, M1 Data and Analytics (OneCare vendor)

Member and Other Vermont Stakeholder Perspectives

Other Considerations

- Lack of awareness of services and where to refer people or where to tell people to go to get help once they are identified. Need for a lot more training and education around HCBS. Many don't even know what MNG is.
- VITL and OneCare have access to large data sets, although not everything is connected. Are willing and able to provide data if have parameters around what need to be analyzed.
- Use of statewide, standardized SDOH screening tools at point of care (e.g., PCP visits) that could assist in identifying Vermonters in greatest need, particularly around needs such as food insecurity, transportation, social isolation. OneCare very interested in exploring this further and implementing once they identify a tool.
- VITL, OneCare, and Blueprint work together and share data in collaboration with state.

Menti Poll

Please go to www.menti.com and use the code 2480 1412

Please input the strategies in the Menti poll.

How would you define "in greatest need"? What does this mean to you?

Open Discussion

- Framing Questions 1-4
- Other Ideas and Suggestions

Open Discussion: Question #1

How do we define "in greatest need"? What does this mean to you?

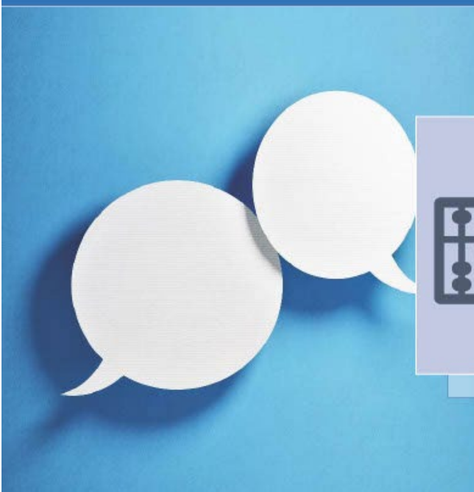
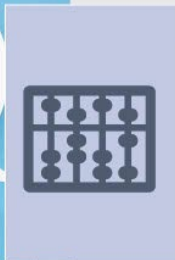
Open Discussion: Question #2

What data sources are most important to consider for identifying this population?

Open Discussion: Question #3

Where and how would this data be accessed and used?

Open Discussion: Question #4

What other new strategies, in addition to data sources, can be used to identify this population?

Menti Poll

Please go to www.menti.com and use the code 2480 1412

Please write your responses in the Menti poll.

What are the most important methods/strategies for identifying Vermonters across all payers in greatest need of extended supports?

Meeting #6 Planning

Topic: How best to support family caregivers, such as through training, respite, home modifications, payments for services, and other methods

What are the current barriers caregivers experience in accessing already available resources?

What are the gaps?

What are the most promising strategies/approaches?

Meeting #6 Planning

Approach

- Identify small group of interested and knowledgeable members who would like to prepare for our next meeting and share ideas and thoughts.

Interested parties?

- Please raise your hand or let us know if you'd like us to follow up with you.

Closing

- Review Action Steps
- Wrap Up

Vermont Extending HCBS Workgroup Meeting #6

June 26, 2023
1:00 – 3:00pm

Agenda

1:00 – 1:05pm	Welcome and Introductions
1:05 – 1:15pm	- Overarching themes from May meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:30pm	- Present topic for discussion and questions for consideration - Present challenges and barriers for discussion
1:30 – 1:50pm	- How to best support family caregivers, such as through training, respite, home modifications ,payments for services and other methods - National and state innovations - Menti poll: Which state and national innovations are of greatest interest?
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Menti poll: What are the best methods for supporting caregivers? (Pick your top three) - Meeting #7 planning - Review action steps - Wrap up

Welcome and Introductions

Round Robin Welcome: Please write your name in the chat so we can track who is here!

Meeting # 5 Topic for Discussion

"How to proactively identify Vermonters across all payers who have the greatest need for extended supports."

Meeting #5 Overarching Themes

Populations to Consider

- People impacted by COVID and long-term chronic conditions
- Homeless
- Immigrants and migrant populations
- People with disabilities who are new parents
- People who are having a hard time being diagnosed or are feeling cut off due to pandemic impacts
- People about to be homeless or releasing people with no plan.
- Brain injury survivors

Data Sources and Methods to Consider

- Need to start with primary care practices, community health teams, SASH and other providers who are first touchpoints for populations
- Consider paying people for time or offering people something for their time for completing screens. Make sure everything is accessible (meeting spaces, captioning on Zoom, etc.)
- Need to remember that when some entities ask these questions, (screening and assessments) they are not asked in an equitable manner. Need to be sensitive to how and when they are asked.
- VITL: think about using AI and other ways to take notes and put into electronic form to help mine data and identify people that are being served but typically don't have data captured on them. Also, must think about who can use what data and for whom?
- Need to consider that talking to people is often the best way to get information. There needs to be a human connection beyond just data

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Meeting #5 Overarching Themes

Where and How Would this Data Be Accessed and Used?

- Need to think about why we are seeking data and how it will be used. What are we going to do with it?
- Using data to prioritize outreach to those in need is not how we typically use data but it can be very helpful when thinking about need and how to present to the Legislature.
- Look at

Other New Strategies, In Addition to Data Sources, Can Be Used to Identify This Population?

- Consider how many small towns we have that know people. Use our town clerks, town nurses, community health teams. Reach out to Racial Justice Alliance, Migration Justice Alliance. Develop points of outreach
- Use emergency responders, crisis centers, police, clergy
- Use social media campaigns and get people on TV. Use Facebook.
- Use Designated Agencies.
- Go back to original premise of MNG to delay or prevent NH placement/institutionalization and determine whether it is doing what it was intended to do. What should we be measuring to do this? What data do we need?
- In addition to common medical and health data, what data can help support quality of life. Think about dental health/needs, nutrition, housing, and other SDOH.

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Menti Poll Results: How Would You Define "In Greatest Need"? What Does This Mean to You?

- People who are at highest risk of institutionalization
- People who have traditionally been in marginalized groups
- Someone who does not have support from family/friends and have health needs
- People not connected to traditional programming
- People who live alone
- People who tell us they have a need and are turned away from multiple organizations
- People who live in poverty
- Not having basic needs met (STABLE housing, food, medical providers) and not being connected to programs that can help with organization/executive functioning
- People experiencing social isolation/loneliness
- Those who make more money to qualify for Medicaid but can't pay for services
- People who don't qualify for other services
- Individuals with unmet needs (including unmet ADL/IADL needs, food security, shelter, etc.) who are not eligible for other programs or for whom other programs would not adequately address those needs
- Those who have caregivers who need a break
- Individuals who are at risk of losing housing and worsening health if services are not provided
- People with multiple needs such as mental and physical health
- People who end up in jail instead of getting services
- People who don't know where to go/who to turn to for help
- Those who don't understand what is being communicated about programming
- Caregivers who are suffering (health/mental health) issues

Menti Poll Results: Most Important Methods/Strategies for Identifying Vermonters Across All Payers in Greatest Need of Extended Supports

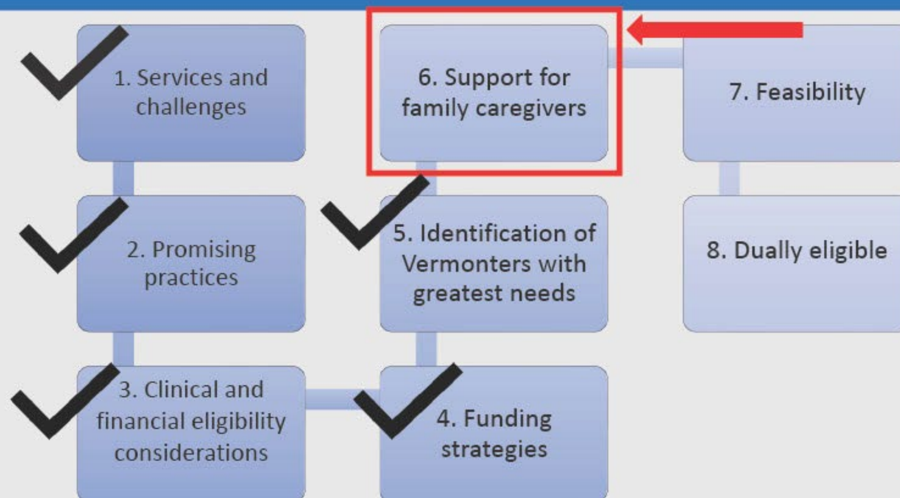
- PCP offices, hospitals, talking with both person who needs care and their caregivers
- Hairdressers/barbers
- PCP/CHT/SDOH Screens
- Accessing participants in conversation and being available for follow up for them
- Librarians
- List out traditionally underserved areas and develop outreach plan
- Hospital visits/ER visits/PT, OT, other therapy centers
- Senior centers
- Churches
- Local radio/local TV
- Transportation providers
- Town meetings
- "Third space" places

Meeting #5 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

Reminder: Planned Topics



Meeting # 6 Topic for Discussion

"How to best support family caregivers, such as through training, respite, home modifications, payments for services and other methods."

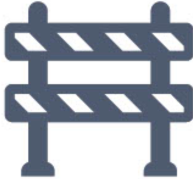
Meeting #6 Questions for Consideration

What are the current barriers caregivers experience in accessing already available resources?

What are the gaps?

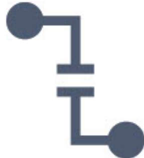
What are the most promising strategies and approaches to best support family caregivers?

Member Perspectives: Barriers



- Qualifying for services: age and income
- Geography: services not available in all areas
- Caregiver exhaustion, lack of time, often working, have their own challenges
- Lack of awareness of what is available to help
- Unfamiliar with the system and need help with applications or other 'paperwork'
- System barriers:
  - Difficult to navigate
  - Doesn't connect CGs to services – they just give out phone numbers
  - Certificate of need requirements: by regulation, resources are stuck in silos and impedes service delivery
  - Application process for programs and ease of enrollment: too many forms, redundant questions, too complicated and requires someone familiar with system to complete
  - Cost of private providers is too high with minimum hours required
  - Staffing for state programs is low when private providers have staff but state/federal $$ can't pay for it
- More men are caregivers and Vermont mindset results in not wanting to reach out for help; stigma attached to dementia; Persons with dementia find it difficult to accept people into their homes

Member Perspectives: Gaps



- Lack of awareness of services
- Needs to be ongoing cross training of staff at CBOs. Staff turnover and knowledge is lost
- Lack of ability to purchase services if you can afford it
- Access to support groups and 1:1 counseling – shortage of social workers, MH clinical or geriatric psychologist
- Case management not available as stand along service
- Support for caregivers to even be able to go to trainings or a support group. Adult day services can help with this
- Support for the entire family system, which complicates things
- No option to purchase services
- Availability/flexibility of respite services – each caregiver had different needs for respite

Member Perspectives: Promising Strategies

- Dementia family caregiver center piloting a volunteer mentoring program that hopes to go statewide
- Caregiver peer to peer support groups
- State provide funding for navigation support at the local level. Each community or region should have one.
- Drop in respite to check on people (e.g., by churches and other local CBOs)
- Expansion and development of programs that support both the person and the caregiver. Also addresses socialization and loneliness.
  - Adult day
  - PACE

Where Vermont is Today

- Vermont is home to an estimated 25,000 family caregivers for people with Alzheimer's and other dementias*
- Vermont's unpaid, informal support network provides approximately 36,000,000 hours of care annually, valued at $717,000,000*
- All five AAAs provide Family Caregiver Support Services
- Dementia Respite Program offering small grants to unpaid caregivers including in-home services, adult day, and personal respite for the caregiver
- Use of programs such as Powerful Tools for Caregivers™ and TCARE, including TCARE's caregiver assessment tool

* 2015 – 2019 Behavioral Risk Factor Surveillance System survey (VT Department of Health)

Vermont's State Plan on Aging (2023 – 2026)

Goal #3: Bolster the recognition and support of unpaid caregivers in Vermont

Key Objectives:

- Increase public awareness and recognition of the diverse needs, issues, and challenges faced by family caregivers
- Increase collaboration across the aging network to support Grandparents raising grandchildren
- Family Caregiver Support: Ensure family caregivers have a support system in place to meet them where they are in their caregiving journey

*2023 – 2026 Vermont State Plan on Aging

Vermont's State Plan on Aging (2023 – 2026)

Goal #3: Bolster the recognition and support of unpaid caregivers in Vermont

- Informed by the Older Vermonters and Family Caregiver Needs Assessment
- Family Caregiver Survey findings*
  - The majority of family caregivers provide care to their family member between 20 hours and 24/7 on a weekly basis
    - 28% of caregivers provide care on a 24/7 basis, with half of those caregivers being spouses
  - 53% of family caregiver respondents have been caregiving for no fewer than four years
  - Less than 25% of family caregivers use respite services
    - Don't know what is available or where to find respite care
    - Can't afford it
    - Person being cared for won't accept it
  - Over 50% of family caregivers would like to learn more about self-care, medical benefits, LTSS, estate planning, and medical conditions
  - Friends, family members, health care providers, and the Internet were the most common sources of support and information followed by HHAs, Senior Helpline, social media, libraries and VT 211

*2023 – 2026 Vermont State Plan on Aging

Where Vermont is Today: 7th in Support for Family Caregivers* (level of policy adoption)

One of the top four states with the highest percentage of its population age 65+ (21%)

Supporting Working Caregivers
- Family responsibility protected classification: none or minimal
- Exceeds federal FMLA: moderate
- Paid family leave: none or minimal

Supporting Working Caregivers
- Mandatory paid sick days: high
- Flexible sick days: high
- Unemployment insurance for family caregivers: none or minimal

Person and Family Centered Care
- Spousal impoverishment protections: moderate
- Having caregiver assessment: moderate
- CARE Act legislation: none or minimal

Nurse delegation and scope of practice
- Nursing tasks to be delegated: high
- Nurse practitioner scope of practice: high

Transportation Policies
- Volunteer driver protection: high

*2020 LTSS Scorecard

National Family Caregiving Improvements in Person and Family-Centered Care*

- 29 states improved significantly on this indicator measuring:
  - State policies on financial protection for spouses of Medicaid beneficiaries who receive HCBS
  - Assessment of family caregivers' own needs
  - Enactment of the Caregiver Advise, Record, Enable (CARE) Act
- The largest improvement was in state use of family caregiver assessments for caregiver health needs and well-being. Twenty-four states saw significant improvements in this area, with 41 states now conducting family caregiver assessments. However, most of these are conducted in smaller family caregiver support programs, and not Medicaid programs
- Nine additional states enacted the CARES Act, bringing the national total up to 41.

*2020 LTSS Scorecard

RAISE Act: State Strategies and Promising Practices*

1. Use broader definitions of family caregiver.
2. Administer the BRFSS Caregiver module.
3. Use family caregiver assessments and plans of care as aggregate data collection.
4. Prioritize collecting family caregiver data and outcomes.
5. Compile state inventories of family caregiver services.
6. Develop state evaluations of family caregiving programs.
7. Implement evidence-supported programs for family caregivers.

https://nashp.org/raise-act-state-policy-roadmap-for-family-caregivers/

2022 National Strategy to Support Family Caregivers

Goals:

1. Increase awareness of and outreach to family caregivers
2. Advance partnerships and engagement with family caregivers
3. Strengthen services and supports for family caregivers
4. Ensure financial and workplace security for family caregivers
5. Expand data, research, and evidence-based practices to support family caregivers

2022 National Strategy to Support Family Caregivers
Financial and Workplace Security for Family Caregivers

- **Refundable Caregiver Tax Credit**
  - Nebraska, North Dakota, Oregon
- **Non-Refundable Caregiver Tax Credit**
  - Missouri, Oklahoma
- **Family Caregiving in Unemployment Insurance Eligibility**
  - DC and 24 states include caregiving responsibilities as “good cause” for leaving a job, allowing caregivers to be eligible for unemployment insurance payments while they are out of work caring for a family member.
- **Publicly Funded Long-Term Care Benefits**
  - Washington and Hawaii

VA Program of Comprehensive Assistance for Family Caregivers (PCAFC)

Overview

- The VA MISSION Act, enacted in 2018, expanded the PCAFC to include family caregivers of eligible Veterans who served prior to 9/11/2001 and in October 2022, expanded the program to Veterans serving in all eras
- Family caregivers receive a monthly financial stipend
- Caregivers must be at least 18 years of age
- May be a spouse, son, daughter, parent, stepfamily member, extended family member or lives with, or willing to live with Veteran but not related
- Must require in-person personal care services for at least six continuous months
- Includes caregiver assessment as well as Veteran assessment, eligibility assessment, and in-home assessment

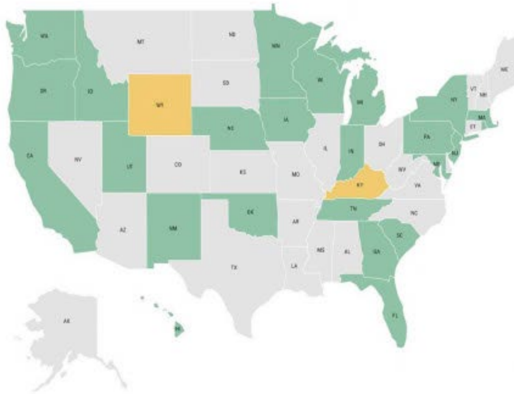
Services

- Monthly stipend: based on formula including geographic locality
  - Level 1:upwards of $1,800/month
  - Level 2: upwards of $3,000/month
- Caregiver training
- Access to health insurance
- Counseling
- Respite care
- Legal and financial planning services

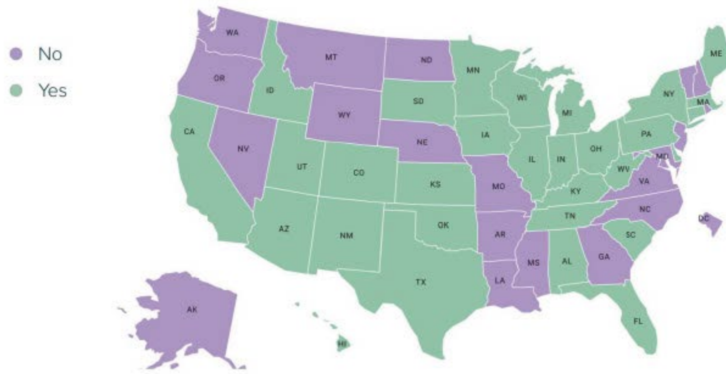
Medicaid Innovations

- States are exploring how Medicaid options can support LTSS/HCBS participants through consumer-directed programs that allow hiring of care providers directly vs through and agency including allowing family members to be paid for providing care
- All states have at least one consumer-directed LTSS option
- In a NASHP environmental scan of states' Medicaid 1915c HCBS programs for older adults and persons with disabilities, 24 states provide some form of education, training, or counseling to family caregivers
- Use of ARPA Section 9817 funds
  - 30 states are using some of this funding to support family caregivers
    - Respite care: 12 states
    - Training and education: 17 states
    - Payments to caregivers: 7 states

Medicaid Innovations



Medicaid Innovations



Health System Transformation, LLC

Medicaid Innovations

- **Indiana** proposes a caregiver support grant for technology to reduce caregiver loneliness and funding for a gap analysis of family caregiving services
- **Connecticut** plans to implement permanently the Care of Persons with Dementia in Their Environments (COPE) evidence-based support model. They are studying the return on investment using Medicaid utilization, need for paid caregivers, unpaid caregiver burnout, and quality of life improvement
- State use of 1915c Appendix K amendments allowing family caregivers to provide services and receive reimbursement when there isn't a hired aide available. However, these amendments expire soon (six months following the end of the PHE)

Health System Transformation, LLC

Other State Innovations:
Oregon Family Caregiver Assistance Program

Five-year 1115 Waiver Demonstration Request Pending Approval (11/2021)

- A gap exists for individuals not yet eligible for Medicaid HCBS, yet who have limited income and are at risk of entering the Medicaid system.
- Some of these individuals receive care from family or unpaid caregivers, while others do not have a caregiver for support with ADLs.

Intention:

- Offer a more robust set of alternative services that can provide a limited, preventative array of services and supports so that a greater number of older adults and younger adults with disabilities can maintain their independence and continue living in their own homes.
- Projecting small savings to Medicaid program at end of 5-year demonstration

Other State Innovations:
Oregon Family Caregiver Assistance Program

Overview

- For older adults and adults ages 18 and over with physical disabilities who are not currently accessing Medicaid programs
- Support consumers whose family members have chosen to care for their loved ones in their own homes
- Design consumer-directed services that meet the consumer's needs while sustaining the needs of the caregiver and overall caregiver relationship
- Consumers choose from list of services to support and sustain caregiving relationship
- Projected 1,800 individuals will be served
- Income at or below 400% of Federal Poverty Level (FPL)
- Resource limit up to the average cost of six months in a nursing facility
- Functional eligibility using the OR Priority Level System
- Funding capped at $500/month

Services

- In-home support services or personal care services
- Chore services
- Adult day services
- Respite services
- Emergency response systems
- Supports for consumer direction
- Assistive technology
- Minor consumer home modifications
- Home delivered meals
- Assisted transportation, in conjunction with another services
- Supportive services (counseling, groups) for individuals and their caregivers
- Family Caregiver Hotline
- Education and training for unpaid caregivers; and
- Case management and service coordination (to individualize and integrate social and health care options for the consumer

Other State Innovations: Hawaii Kapuna Caregivers Program

Overview

- Provides assistance to Hawaii caregivers who are employed at least 30 hours per week
- Based on an assessment of the care recipient who must reside in Hawaii
- Care recipients may receive up to $210 worth of Kupuna Caregiver services weekly
- Funds will be paid directly to the service provider, not to the primary caregiver
- $70/day direct stipend payments to caregivers
- While not means-tested, includes a holistic assessment of the caregiver and care recipient

Services

- Adult Day Care
- Assisted Transportation
- Chore
- Home-Delivered Meals
- Homemaker
- Personal Care
- Respite Care
- Transportation

Other State Innovations: Washington Tailored Supports for Older Adults

Overview

- TSOA funded under Medicaid Transformation Project Demonstration to support unpaid caregivers
- For people age 55+ who are "at risk" of needing LTSS and who currently don't meet Medicaid financial eligibility criteria but must meet functional eligibility criteria/NFLOC
- Provides small personal care benefit to people who don't have an unpaid family caregiver
- Includes a presumptive eligibility component allowing services to be authorized based on a quick prescreening of financial and functional eligibility criteria; this allows for services for up to 60 days while the application is being processed
- Use of TCARE assessment

Services

- Personal care
- Nurse delegation
- Support groups and counseling
- Specialized medical equipment or supplies
- Respite
- Housekeeping and errands
- Adult day care
- Home-delivered meals
- Health maintenance and therapies for the caregiver

Other State Innovations:
Structured Family Caregiver Waiver

- At least seven states have implemented some version of a Structured Family Caregiving (SFC) Waiver
- Provides direct payments to the caregiver as well as additional supports.
- Eligible waiver participants are Medicaid beneficiaries with NFLOC need. (e.g., HCBS waiver participant).
- Does not require ability to self-direct
- The designated SFC agency receives a per diem from the state, and a percentage of that (over 50%) is passed on to the caregiver as a stipend

Other State Innovations:
Medicaid Structured Family Caregiving

- The caregiver is either a family member or someone who has a significant relationship to the participant.
- Ideally, the caregiver is already caring for the participant when he or she qualifies for the service.
- **Missouri** has established the existence of a preexisting relationship as a requirement.

- Designed to enable the caregiver to make caregiving their primary focus.
- Relieves the financial pressure on the caregiver to work outside the shared home.
- A back-up caregiver or respite care enables the caregiver to safely leave the participant to take care of other important tasks, including self-care.
- **Georgia** established a policy that to qualify for SFC services, the caregiver must be unable to work outside the home due to caregiving responsibilities

- Caregivers are not employed by the waiver participant but rather paid by an SFC agency that is responsible for making sure caregivers are qualified and trained to succeed in completing their specific tasks, that the tasks are completed as needed, and that caregivers respond to changes in participants' needs.
- **Georgia** requires SFC agencies to provide caregivers with web-based support for tracking information, such as daily notes, that is shared across the caregiver, care coordinator, and others.

Menti Poll

Please go to www.menti.com and use the 8249 0773

What are the best methods for supporting family caregivers?

Please write in your ideas.

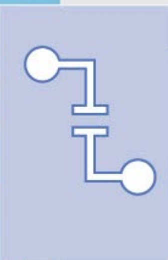
Open Discussion

- Framing Questions 1-3
- Other Ideas and Suggestions

Open Discussion: Question #1

What are the current barriers caregivers experience in accessing already available resources?

Open Discussion: Question #2



What are the gaps?

Open Discussion: Question #3

What are the most promising strategies and approaches to best support family caregivers?

Menti Poll

Please go to www.menti.com and use the code 8249 0773

Which state and national innovations are of greatest interest?

Please write your responses in the Menti poll.

Meeting #7 Planning

Topic: The feasibility of extending access to long- term home and community-based services and supports and the impact on existing services.

What are the best methods and most promising opportunities for allowing case management to be provided to people who do not require other services?

What are the fiscal concerns of extending access to HCBS?

What are the potential impacts on existing services?

Meeting #7 Planning

Approach

- Identify small group of interested and knowledgeable members who would like to prepare for our next meeting and share ideas and thoughts.

Interested parties?

- Please raise your hand or let us know if you'd like us to follow up with you.

Closing

- Review Action Steps
- Wrap Up

Vermont Extending HCBS Workgroup Meeting #7

July 17, 2023
1:00 – 3:00pm

Agenda

1:00 – 1:05pm	Welcome and Introductions
1:05 – 1:15pm	- Overarching themes from June meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:30pm	- Present topic for discussion and questions for consideration - Present challenges and barriers for discussion
1:30 – 1:50pm	- **The feasibility of extending access to long- term home and community-based services and supports and the impact on existing services** - National and state innovations - Menti poll:
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Menti poll: - Meeting #8 planning - Review action steps - Wrap up

Welcome and Introductions

Round Robin Welcome: Please write your name in the chat so we can track who is here!

Meeting # 6 Topic for Discussion

"How to best support family caregivers, such as through training, respite, home modifications, payments for services and other methods."

Meeting #6 Overarching Themes

Current Barriers

- Caregivers are overwhelmed
- Many caregivers are still working and they are juggling too much
- Caregivers don't know where to look for information or don't have the time
- Organizations that are there don't know enough about what programs and services are available to help caregivers and their loved ones
- Some kind of resource navigation or care navigation is needed
- Clients or the person needing services can sometimes be the barrier; not accepting of services; are afraid to get help (e.g., migrant populations)
- Too much paperwork to get through and too much duplication
- Geographic: not all services available equally

Gaps

- Current assessments are not capturing executive functioning challenges or for people with cognitive changes and challenges
- Financial divide: those who can afford to pay for supports and those who can't, but are not eligible for any public assistance
- Support groups for all different types of caregivers, including younger caregivers

Promising Practices and Approaches

- Consider a system of care like the I/DD system
- Trualta and TCare are very helpful and used by the AAAs – can this be expanded?
- Develop role for care navigators or something like that – look into models and studies in Scandinavia
- Implement campaign, something like "Ten signs you might need caregiver support".
- Financial calculator to project out expenses for care to help plan better
- Need to consider how adult day supports not only the person, but the caregiver as well. It helps the entire system
- Use of technology to support both the person needing services and the caregiver; use of blink systems with two-way talking, web cameras, other ways to check in remotely and communicate
- Behavioral support coaching
- We have the information, we need better ways to get the information out: women circles, local approaches with trusted channels
- Caregiver mentor programs
- Caregiver peer supports
- Train geriatric social workers

Menti Poll Results: What are the best methods for supporting family caregivers?

- Start with assessment to really understand needs/goals comprehensively
- Listening and coaching
- Direct funding, respite, options for people not on Medicaid (middle class, lower middle class), expanding matching of volunteers
- Paying them for the work they are doing
- Provide respite resources. Provide stipends directly to caregivers for work they are doing
- Emotional support
- A person who can listen and create a relationship of support in figuring out with the caregiver their unique needs
- Provide more flexible funding to pay for respite services (in-home care, adult day, out of home respite, etc.)

Menti Poll Results: Which state and national innovations are of greatest interest?

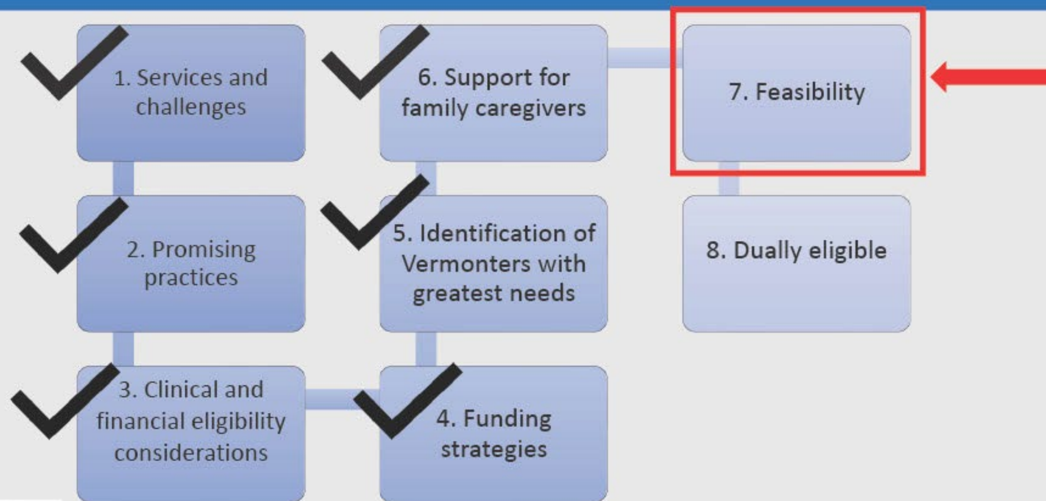
- I appreciate the presumptive eligibility in programs overall
- Tax credits
- Paid family leave
- Structured family caregiver waiver: Hawaii model – support for working caregivers
- The Hawaii program sounds amazing. Curious how it is funded
- Many different options: one size doesn't fit all
- Some of the programs that offer some financial break to caregivers
- The creative ways states are working to address gaps between eligibility and need around caregivers. The caregiver tax credit. Letting caregivers leave work be eligible for unemployment benefits
- Better expansion of eligibility

Meeting #6 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

Reminder: Planned Topics



Meeting # 7 Topic for Discussion

"The feasibility of extending access to long- term home and community-based services and supports and the impact on existing services".

Meeting #7 Questions for Consideration

Is it feasible to extend access to long-term HCBS?

If feasible, what would that look like? What would a "to be" or "future state" look like?

What would be the impacts on existing services that need to be considered?

Member Perspectives: Concerns and challenges

- The system is set up so that you either get something, or nothing
- Variability across the state in terms of resources/services and supports
- Current guidelines don't allow for creativity or flexibility to help people who are in need of supports
- If extend access, this brings up concerns related to:
  - Provider impacts – rates
  - State impacts – caseload increases and increases in budget
  - Workforce impacts – can't meet need of current clients
- Will extending access create greater prioritization problems?

Member Perspectives: Ideas

- Establish a role for a care navigator or something like that – what would this look like? What would this person do?
- When we think about case management and "decoupling" from the need for services, are we defining case management correctly? Is case management the right term?

Recap of Work Group Ideas for Extending Access to HCBS

Flexible Funding

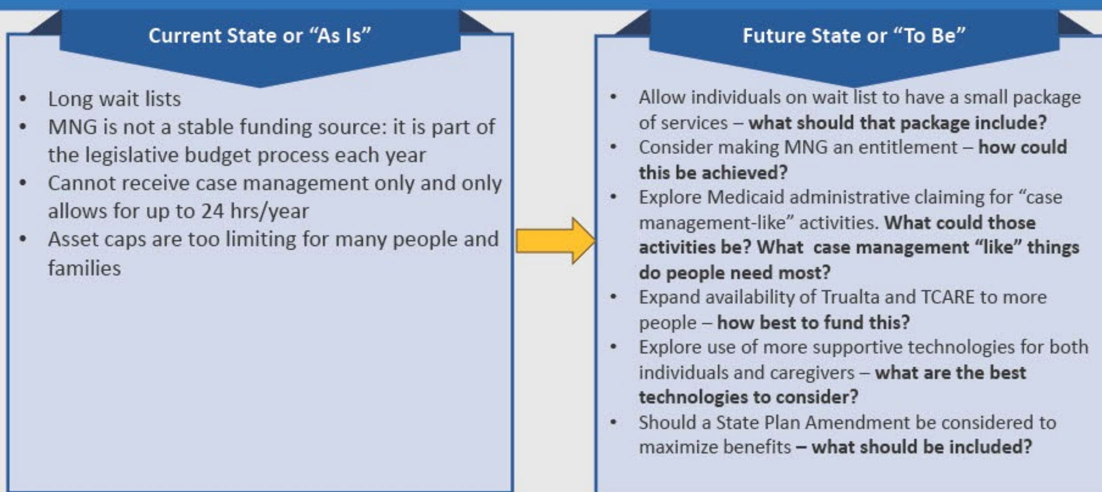
1. Personal care, respite, companion services, homemaker.
2. Transportation (for medical or non-medical purposes).
3. Defined budget to use flexibly.
4. Technologies that support individuals with ADLs/IADLs.
5. Home modifications or other adaptations.
6. Transition or sustainable housing services and supports.
7. Nutritional supports or home delivered meals.
8. Purchasing home goods or appliances

The overarching preference for expanding access to HCBS was through more flexible funding.

Flexible Funding

1. Pay caregivers.
2. Communication access and expansion of ASL interpreter services.
3. Communication and broadband access challenges, phone reimbursement for people to access social opportunities, telehealth options that would allow for video.
4. Service animals.
5. Emotional health, mental health, wellness, and prevention.
6. Things that are preventive such as healthy foods, exercise, healthy checkups.
7. Supports that are not pulling on the existing workforce like PERS. Expand PERS to more people.
8. Fund medical alert bracelets and the engraving costs.
9. Expand services like reminder calls for taking medications that eliminate the need for someone to come to their home.

Innovations: Moving from the "as is" to the "to be"



Menti Poll

Please go to www.menti.com and use the xxxx xxxx

What are the most important "to be" or "future state" considerations?

Please write in your ideas.

Open Discussion

- Framing Questions 1-3
- Other Ideas and Suggestions

Open Discussion: Question #1

Is it feasible to extend access to long-term HCBS?

Open Discussion: Question #2

If feasible, what would that look like? What would a "to be" or "future state" look like?

Open Discussion: Question #3

What would be the impacts on existing services that need to be considered?

Menti Poll

Please go to www.menti.com and use the code xxxx xxxx

What are the best "feasible" ideas for extending access to HCBS?

Please write your responses in the Menti poll.

Meeting #8 Planning

Topic: Potential changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication.

What are the possible changes to service delivery?

What are some high impact, low cost changes?

What are some high impact, high cost changes?

Meeting #8 Planning

Approach

- Identify small group of interested and knowledgeable members who would like to prepare for our next meeting and share ideas and thoughts.

Interested parties?

- Please raise your hand or let us know if you'd like us to follow up with you.

Closing

- Review Action Steps
- Wrap Up

Vermont Extending HCBS Workgroup Meeting #8

August 21, 2023
1:00 – 3:00pm

Agenda

1:00 – 1:05pm	Welcome and Introductions
1:05 – 1:15pm	- Overarching themes from July meeting - Any additional thoughts to add? - Any follow-up questions to address?
1:15 – 1:30pm	- Present topic for discussion and questions for consideration - Present challenges and barriers for discussion
1:30 – 1:50pm	- **Topic for Discussion: Potential changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication.** - National and state innovations - Menti poll: What are your biggest concerns about duplication of services?
1:50 – 2:50pm	Open Discussion
2:50 – 3:00pm	- Menti poll: What innovations and potential changes are most important? - Closing of workgroup meetings - Next steps for development of report and recommendations - Wrap up

Welcome and Introductions

Round Robin Welcome: Please write your name in the chat so we can track who is here!

Meeting # 7 Topic for Discussion

"The feasibility of extending access to long- term home and community-based services and supports and the impact on existing services".

Meeting #7 Overarching Themes

Feasibility

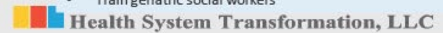
- Inconsistent funding stream: needs to change to be "feasible"
- Current waitlists impact feasibility: consider prioritization
- Workforce issues impact feasibility

Future State or "To Be" State

- Current assessments are not capturing executive functioning challenges or for people with cognitive changes and challenges
- Financial divide: those who can afford to pay for supports and those who can't, but are not eligible for any public assistance
- Support groups for all different types of caregivers, including younger caregivers

Impacts on Existing Services

- Systems of care like for persons with I/DD are helpful: they look at the whole person and the person's family
- Trualta and TCare are very helpful and used by the AAAs – can this be expanded?
- Develop role for care navigators or something like that – look into models and studies in Scandinavia
- Implement campaign, something like "Ten signs you might need caregiver support".
- Financial calculator to project out expenses for care to help plan better
- Need to consider how adult day supports not only the person, but the caregiver as well. It helps the entire system
- Use of technology to support both the person needing services and the caregiver; use of blink systems with two-way talking, web cameras, other ways to check in remotely and communicate
- Behavioral support coaching
- We have the information, we need better ways to get the information out: women circles, local approaches with trusted channels
- Caregiver mentor programs
- Caregiver peer supports
- Train geriatric social workers



Menti Poll Results: What are the most important "to be" or "future state" considerations?

- Services that provide support to the most people - adult day for example
- Consider impact on capacity of system to provide services to those already eligible - limited workforce must be considered at all phases
- Initial package of services on eligibility: case management, PERS, and small ADHM flexible fund ($500 or less) - while waiting for more funding or services
- With anticipated increased need, focus on prevention - services that would have the biggest impact, not sure if that's case management, PERS, or other things.
- I think if we can only offer a small package of services, they should be as tailored to the individual as possible. This will both benefit the users and maximize worker availability.
- Resource navigation that is accessible and no rigid guidelines/hour requirements
- Defining case management as there seems to not be clear understanding of what it is
- Case management vs. Resource Facilitation as options
- Navigators for all. Using technology that we became comfortable with during Covid - Care navigators can work from home - open up workforce availability by employing workers who typically cannot go
- Direct help initially for executive function help with organization, applications, resources, apps and associated help to learn apps...then regular check in for stuff as it comes up and ongoing assessments

tion, LLC

Menti Poll Results: What are the best "feasible" ideas for extending access to HCBS?

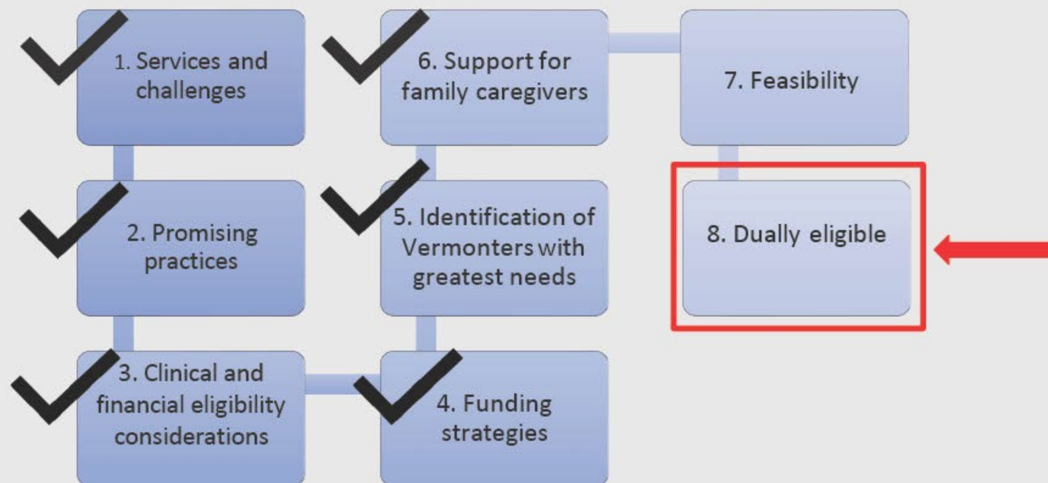
- I think the first step is expanding our ability to understand people's needs and triage accordingly.
- Decouple case management but then have that be comprehensive case management
- Listen/connect to everyone on the waitlist to see what other programs they can explore while on the waitlist so that they don't decline.
- Maybe a recommendation for a statewide assessment of the MNG waiting list, both people on it and the process for managing it.
- Have assessments capture executive function
- Separate case management. Separate funds so that access to life skills and home navigation can occur
- MNG as entitlement / state plan amendment in ways that give stability to the funding so that we don't expand the program and then not have adequate funding
- Executive functions and home life skill supports
- Something for family caregivers
- Assessment of moderate needs list
- Support organizations on getting work permits for immigrants which would also help diversify the workforce
- Manage at state level
- Allow people to be able to purchase case management
- Separate resource navigation from other case management which may cut the number of people on the waitlist. These need to be locally knowledgeable

Meeting #7 Follow-Up

Any thoughts to add?

Any follow-up questions to address?

Reminder: Planned Topics



Meeting # 8 Topic for Discussion

"Potential changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication."

Meeting #8 Questions for Consideration

What are the possible changes to service delivery?

What are some high impact, low cost changes?

What are some high impact, high cost changes?

Member Perspectives

- Service coordination is needed. There is a lack of that service coordination across benefits for Medicare and for Medicaid. What could be possible for the dually eligible populations?
- There are many persons with brain injury who are not eligible for Medicaid as their income is too high, or they have to spend down. What could supports or service offerings for the dually eligible help support?
- For people who are dually eligible, we're trying to help them retain independence for as long as possible. They lose family and friends vs retaining or expanding their network due to the brain injury. They are losing life skills. What supports or services for the dually eligible could help?
- Should PACE be considered again?

Member Perspectives

- Some of the most helpful insights into the experiences of dually eligible Vermonters are at the local level, through members of community health teams, case managers, and frontline staff
- The Blueprint could be a very helpful resource
- OneCare is very open to helping identify dually eligible Vermonters on the MNG waitlist
- Large questions remain:
- How are we determining need?
- How do we assess needs?
- What are the ways we can provide flexibility to meet health care and social needs?
- What identifiers are used to track people on the MNG waitlist?

Background on Dually Eligible

- Dually eligible often have the most complex care needs across physical health, behavioral health, and LTSS.
- Services are often fragmented and uncoordinated due to payment silos, guidelines, and requirements
- More than 11 million Americans enrolled in both Medicaid and Medicare—referred to as dually eligible or "duals"—meet the criteria for each program, including age or disability status for both programs and income requirements for Medicaid.
- Over $300B spent annually across CMS and states.
- There are less than 50,000 dually eligible beneficiaries in Vermont.
- Vermont does not offer "dual eligible" health plans, otherwise referred to as Dual Eligible Special Needs Plans, or DSNPs for short.
- Less than 10% of dually eligible individuals are enrolled in an integrated care program.
- The one program in Vermont that targeted dually eligible beneficiaries was PACE Vermont, Inc., or Program of All-Inclusive Care for the Elderly, which closed in 2013.

PACE Vermont, Inc.

- While closed in 2013, PACE Vermont, Inc. began in the early to mid 2000's and was a service option under Choices for Care
- One of the only service options targeting dually eligible Vermonters

Eligibility Criteria

- Must be at least 55 years of age
- Be a Medicare beneficiary
- Be financially and clinically eligible for Medicaid (meet NFLOC)

Benefits Package (at the time)

- Interdisciplinary care team assessment and treatment planning
- Primary care services including physician and nursing
- Social work services
- Restorative therapies, including PT, OT, ST
- Medications – delivered to home
- Personal care and supportive services
- Nutritional counseling
- Transportation to medical appointments
- Meals at PACE site
- Medical specialty services
- Laboratory tests, x-rays, other diagnostic procedures
- Drugs and biologicals
- Prosthetics and DME, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance,
- Acute inpatient care
- Nursing facility care

Duplication of Services

- Where are the largest risks for duplication?
- Case management impacts?
- Chronic Care Initiative impacts?
- Community Health Team impacts?

Potential Changes to Service Delivery

- What modifications could be considered that reduce or eliminate concerns around duplication?
  - **OneCare Vermont**: Approximately 54% of Vermont Medicare beneficiaries (roughly 80K people) are attributed to OneCare VT, which includes people eligible for both Medicaid and Medicare
    - What role could OneCare's population health and care coordination model play in serving and expanded group of Vermonters, and those who are dually eligible?
  - Should the **PACE Vermont, Inc.** be revitalized or reconsidered? Are there continued concerns around operational sustainability? Are there compelling reasons to consider further exploration?
  - Can Vermont capitalize on existing Medicare health plan offerings, such as **Medicare Advantage plans**, to extend services to dually eligible members?

National and State Innovations: MA Duals 2.0

- MA has three integrated programs that serve duals:
  - PACE
  - Senior Care Options (SCO) for persons age 65 and older
  - One Care (for persons age 21-64)
- Submitted to CMS a Duals Demonstration 2.0 Concept Paper that includes enhancements to the existing SCO and One Care programs under a newly aligned 1115A Demonstration
- Currently still under review
- Goals:
  - Increase access to integrated care management
  - Improve quality of care by better aligning One Care and SCO
  - Encourage enrollment of current FFS duals
  - Reform financing models including changing capitation rate methodology to bridge similar risk adjustment mechanisms

Menti Poll

Please go to www.menti.com and use code 7769 3024.

Please write in your ideas.

What are your biggest concerns about duplication of services?

Open Discussion

- Framing Questions 1-3
- Other Ideas and Suggestions

Menti Poll

Please go to www.menti.com and use the code 7769 3024

Please write your responses in the Menti poll.

What innovations and potential changes are most important?

Workgroup Closing

Thank You!!!

You plant seeds every single day, in the world and in others,
with every thought you think and word you speak and action you take.

You're making a dent in the universe and you matter, in a very real way.
~ Jennifer Williamson

Appendix E: State and National Research and Summaries

Theme 1: Services Needed

State Strategies, Programs, and Practices

Several state models support the workgroup's interest in prioritizing use of flexible funding or expansion of services. **Table 3** below highlights key features of each state's approach to offering greater flexibility in program design, services, and funding.

Table 3: State Models Supporting Flexibility and Service Expansion

State	Service Model
Oregon	Three models of interest: 1) Five-year 1115 Waiver demonstration request currently pending CMS approval a. Targeting individuals not yet eligible for Medicaid HCBS with limited incomes and at risk of entering the Medicaid system. Adults with incomes up to 400% of the Federal Poverty Level (FPL) who pass a resource test and meet certain clinical eligibility criteria would be eligible b. Will offer a limited, preventative array of services and supports so that a greater number of older adults and younger adults with disabilities can maintain their independence and continue living in their own homes 2) Oregon Project Independence (OPI)[23] a. Started in 1975, provides federal match for existing state-funded OPI b. Consumers will choose from list of limited supports to help maintain independence (e.g., in-home support/personal care, chore services, adult day, RN services, assistive technology, emergency response systems, home delivered meals, caregiver supports, evidence-based programs, options counseling, transportation, education and training, case management and service coordination) c. There are no limits on program enrollment but there is a high demand and waitlists d. Ninety percent (90%) of members do not enter the Medicaid HCBS system 3) Oregon Health Related Services (HRS)[24] are non-covered services under OR's Medicaid State Plan intended to

[23] State of Oregon: SUA - Oregon Project Independence (OPI)
[24] OHA-Health-Related-Services-Brief.pdf (oregon.gov)

	improve care delivery and overall member and community health and well-being. The goals are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. It includes flexible services that supplement covered benefits and community benefit initiatives that are not limited to Medicaid only members but serve a broader population to improve health and health care quality
California	As part of its 1115 Waiver, CA includes "In Lieu of Services" to address SDOH. As part of CalAIM (CA's Medicaid program), Medicaid members are connected to Community Supports[25] to address their health-related social needs (HRSN) including medically supportive foods and housing supports. There are currently 14 pre-approved Community Supports.
Washington	Tailored Supports for Older Adults[26] provides flexible funds and guidance from a care manager or services navigator so people can purchase what they uniquely need and fill the gaps that exist, allowing them to remain in the community.
Massachusetts	MassHealth's (MA's Medicaid program) Flexible Services Program (FSP) is testing whether MassHealth Accountable Care Organizations (ACOs) can reduce the cost of care and improve their members' health outcomes by paying for certain nutrition and housing supports through implementing targeted evidence-based programs for certain members. Expanded services include case management and two categories of HRSN: Tenancy Preservation Supports and Nutrition Sustaining Supports
Hawaii	Kapuna Caregivers Program[27] is a State of Hawaii-funded program that provides community-based long-term care services. It is intended to provide in-home services to impaired elders who fall in the "gap group." These are elders who do not qualify for other government programs and do not have private assistance to help. This normally includes those with financial resources not high enough to afford the high cost of private-pay services, but not low enough to qualify for regular Medicaid or have levels of care not high enough to qualify for LTC Medicaid (ICF/SNF levels of care).

[25] Transformation of Medi-Cal: Community Supports
[26] Tailored supports for older adults (TSOA) | Washington State Health Care Authority
[27] Honolulu, Hawaii Department of Elderly Affairs Division (EAD) - Services FAQ

Theme 2: Clinical and Financial Eligibility Considerations

State Strategies, Programs, and Practices

Two state programs were highlighted. One addressing financial eligibility and another clinical eligibility. **Table 4** below outlines key elements shared.

Table 4: State Eligibility Models

State	Key Elements
New Jersey	NJ's 1115 Waiver eliminates state review and instead accepts self-attestation of no asset transfers during the five-year look-back period for applicants below 100% Federal Poverty Level (FPL) seeking LTSS and HCBS. New Jersey conducted electronic asset verification of randomly selected applications in 2015 and 2016 and found a 0% error rate on these sampled self-attestations, concluding that "the often-burdensome five-year lookback process can be safely eliminated for many low-income applicants."
Arkansas	AR's Personal Care Services and Independent Choices Program clinical eligibility are quite broad, requiring "hands-on assistance" with at least one ADL. The definition of "hands-on assistance" is the individual would not be able to perform or complete the ADL three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance. While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized.

Theme 3: Supporting Family Caregivers

State Strategies, Programs, and Practices

Several state and national approaches to mitigating caregiver stress and burnout as well as funding supports were discussed. **Table 6** below highlights key elements of those approaches.

Table 6. Caregiver Support Innovations

States	Innovation or Approach (Note: many of these are aimed at individuals with nursing home level of care needs)
Nebraska, North Dakota, Oregon	Refundable Caregiver Tax Credits
Missouri, Oklahoma	Non-Refundable Caregiver Tax Credits
DC and 24 other states	Family Caregiving in Unemployment Insurance Eligibility: includes caregiving responsibilities as "good cause" for leaving a job, allowing caregivers to be eligible for unemployment

	insurance payments while they are out of work caring for a family member.
Washington, Hawaii	Publicly Funded Long-Term Care Benefits
Multiple states	States are exploring how Medicaid options can support LTSS/HCBS members through consumer-directed programs that allow hiring of care providers directly vs through and agency including allowing family members to be paid for providing care
30 states	Use of ARPA Section 9817 funds to support family caregivers including respite (12 states), training and education (17 states) and payments to caregivers (7 states) • Indiana proposes a caregiver support grant for technology to reduce caregiver loneliness and funding for a gap analysis of family caregiving services • Connecticut plans to implement permanently the Care of Persons with Dementia in Their Environments (COPE) evidence-based support model. They are studying the return on investment using Medicaid utilization, need for paid caregivers, unpaid caregiver burnout, and quality of life improvement
Multiple states	Use of 1915c Appendix K amendments allowing family caregivers to provide services and receive reimbursement when there isn't a hired aide available. However, these amendments recently expired due to the end of the public health emergency (PHE)
Oregon	OR's Family Caregiver Assistance Program is for older adults and adults ages 18 and over with physical disabilities who are not currently accessing Medicaid programs. The program is designed to support consumers whose family members have chosen to care for their loved ones in their own homes. OR designed consumer-directed services that meet the consumer's needs while sustaining the needs of the caregiver and overall caregiver relationship. Consumers can choose from a list of services to support and sustain the caregiving relationship. OR projects a total of 1,800 individuals with incomes up to 400% of the FPL will be served. The resource cap is up to the average cost of six months in a nursing facility. Functional eligibility is tied to the OR Priority Level System. Funding is capped at $500/month.
Hawaii	HI's Kapuna Caregivers Program provides assistance to Hawaii caregivers who are employed at least 30 hours per week. Eligibility is based on an assessment of the care recipient who must reside in Hawaii. Care recipients may receive up to $210 worth of Kupuna Caregiver services weekly with funds paid directly to the service provider, not to the primary caregiver. Caregivers receive a $70/day direct stipend payment. While not means-tested, the program includes a holistic assessment of the

	caregiver and care recipient. Services include adult day care, assisted transportation, chore services, home-delivered meals, homemaker, personal care, respite, and transportation.
7 states	At least seven states have implemented some version of a Structured Family Caregiving (SFC) Waiver. It provides direct payments to the caregiver as well as additional supports. Eligible Waiver members are Medicaid beneficiaries with a nursing facility level of care (NFLOC) need. (e.g., HCBS Waiver participant). The Waiver does not require that the person have the ability to self-direct. The designated SFC agency receives a per diem from the state, and a percentage of that (over 50%) is passed on to the caregiver as a stipend.
Georgia, Missouri	Both GA and MO implement the Medicaid Structured Family Caregiving program. The caregiver is either a family member or someone who has a significant relationship to the participant. Ideally, the caregiver is already caring for the participant when he or she qualifies for the service. Missouri has established the existence of a preexisting relationship as a requirement. It is designed to enable the caregiver to make caregiving their primary focus, relieving the financial pressure on the caregiver to work outside the shared home. A back-up caregiver or respite care enables the caregiver to safely leave the participant to take care of other important tasks, including self-care. Georgia established a policy that to qualify for SFC services, the caregiver must be unable to work outside the home due to caregiving responsibilities. Caregivers are not employed by the Waiver participant but rather paid by an SFC agency that is responsible for making sure caregivers are qualified and trained to succeed in completing their specific tasks, that the tasks are completed as needed, and that caregivers respond to changes in members' needs. Georgia requires SFC agencies to provide caregivers with web-based support for tracking information, such as daily notes, that is shared across the caregiver, care coordinator, and others.

Appendix F: Extending HCBS Workgroup Letters

Appendix G: Acronyms

Reference	Acronym
Health System Transformation	HST
Vermont Department of Disabilities, Aging and Independent Living	DAIL
Agency of Human Services	AHS
Social Determinants of Health	SDOH
Supports and Services at Home	SASH
Long-term Services and Supports	LTSS
Independent Living Assessment	ILA
Information Technology	IT
Centers for Medicare & Medicaid Services	CMS
Dementia Respite Grant	DRG
Activities of Daily Living	ADL
Home and Community Based Services	HCBS
Request for Proposal	RFP
Agency of Human Services	AHS
Area Agencies on Aging	AAA
Adult Day Services	ADS
Home Health Agencies	HHA
Personal Emergency Response Systems	PERS
Instrumental Activities of Daily Living	IADL
Primary Care Practice	PCP
Emergency Department	ED
Moderate Needs Group	MNG
Emergency Medical Technicians	EMTs
Vermont Information Technology Leaders	VITL
Artificial Intelligence	AI
Dual Eligible Special Needs Plans	DSNP
Program of All Inclusive Care for the Elderly	PACE
Health Related Social Needs	HRSN
Older Vermonters Act	Act 156 of 2020
Adult Services Division	ASD
Person centered service planning	PCSP
Population Health Logistics	PHL
Caregivers	CG
Medicare Advantage	MA
Senior Care Options	SCO
Aging Services Access Points	ASAP
Federal Poverty Level	FPL
Oregon Project Independence	OPI
Oregon Health Related Services	HRS

Health Related Social Needs	HRSN
Accountable Care Organizations	ACOs
Care of Persons with Dementia in their Environments	COPE
Public Health Emergency	PHE
Structured Family Caregiving	SFC
Nursing Facility Level of Care	NFLOC
Tailored Supports for Older Adults	TSOA
Elderly Affairs Division	EAD
American Sign Language	ASL