WATERBURY OFFICE COMPLEX
208 HURRICANE LANE, SUITE 103
WILLISTON, VERMONT 05495

OFFICE OF THE SECRETARY
TEL: (802) 871-3009
FAX: (802) 871-3001

DOUGLAS A. RACINE, SECRETARY
CHRISTINE OLIVER, DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Senate Appropriations
Senate Health and Welfare
House Appropriations
House Human Services

CC: Doug Racine, Secretary, Agency of Human Services
Susan Bartlett, Special Assistant to the Governor

FROM: Susan Wehry, Commissioner, Disabilities, Aging & Independent Living

DATE: February 15, 2012

SUBJECT: Section E.300(c) of Act 63 of the 2011 Legislative Session

---

Enclosed please find a report on Vermont Choices for Care: Non-Medical Providers that satisfies the requirement of Section E.300(c) of Act 63 of the 2011 Legislative Session. It was prepared by the University of Massachusetts Medical School at the request of the Department of Disabilities, Aging and Independent Living (DAIL).

As you will see, the Report captures the complexities of this issue. As such, DAIL is not seeking legislative action this year but will be working with home health and home care agencies over the next year to cautiously plan for the future of the home care and home health system and address barriers to Vermonters accessing needed services.

Please do not hesitate to contact me if you have questions or would like additional information.

January 2012

Vermont Choices for Care: Non-Medical Providers

Prepared by

Disability and Community Services

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

In cooperation with

Bard Hill

Department of Disabilities, Aging, and Independent Living

Vermont Agency of Human Services

Executive Summary

In the 2011 Vermont legislative session, Act 63 Sec. E. 300 (c) directed the Commissioner of the Department of Disabilities, Aging, and Independent Living (DAIL) to report to the House and Senate Committees on Appropriations, the House Committee on Human Services, and the Senate Committee on Health and Welfare by January 15, 2012 with recommendations regarding the scope of providers that the department may contract with to provide services under the CFC (Choices for Care) program.

In response to this directive, DAIL contracted with us, the external evaluation team for the Choices for Care Waiver (CFC), the University of Massachusetts Medical School (UMMS). We conducted literature/ document reviews, analysis of several other states, secondary analysis of Market Decisions survey data (Robertson, Maurice and Madden, 2011) and stakeholder interviews in order to explore and analyze the possible addition of non-medical CFC Home and Community-Based Services (HCBS) providers in terms of access, choice, cost and financial impact, and outcomes and quality. We find the following benefits and challenges associated with the expansion of CFC providers to include non-medical providers.

Domain	Benefits	Challenges
Access	○ Increases the number of providers ○ Expands the options for participants ○ May allow for the inclusion of providers who are willing to do things differently (e.g. transportation) ○ Offers more staffing opportunities for times of day that are more difficult to cover (evening, overnight and weekend) ○ Expands access to non-medical providers (access that is currently limited to people using Flexible Choices)	○ May complicate the system, making it difficult for participants and families to choose and access services ○ May decrease access to services if Home Health Agencies leave the market
Choice	○ Gives the participant more options ○ Allows the participant to decide which agencies can meet needs the best ○ Empowers the participant who selects a provider to manage services without feeling dependent on one organization ○ May encourage provider agencies to 'compete' for participants by providing high quality and responsive services ○ Permits participants in all locations to have options of service providers ○ Permits participants who choose Consumer-directed/Surrogate-directed services to have another alternative to agency services	○ May create confusion for participants through the addition of more organizations ○ May diminish choice if Home Health Agencies leave the market

Domain	Benefits	Challenges
Cost/ Financial Impact	○ Decreases some service cost (costs per unit switched from HHA higher cost providers to non-medical providers) ○ Reduces some system costs if more people can be supported at home ○ May create incentives for providers to improve wages, benefits and working conditions for direct service workers ○ Creates opportunities for Home Health Agencies to expand service reach by adding a non-medical provider entity to their agencies' menu of service options ○ Would not involve some "start-up" costs for non-medical providers currently operating in Vermont	○ Increases some service unit costs (costs per unit switched from Consumer-directed/Surrogate-directed services to non-medical providers) ○ May create market that is not profitable enough for certain current Home Health Agencies to provide CFC services ○ Compels the State to manage provider taxes and reimbursement rates to ensure no unintended shift in revenues versus costs ○ Increases some costs to providers due to additional reporting to the State ○ Increases some costs to State in administration and oversight of CFC, e.g. additional reporting from providers ○ Increases some costs and resource needs for providers if required training or certification of PCAs is implemented
Quality and Outcomes	○ May offer an incentive for improved training for direct service workers, increasing workforce quality ○ Increases access, one outcome of a high quality system, because participants may be better able to receive all of the services they need ○ Increases opportunities to allow a person to remain at home, a "choice" outcome ○ Competition for participants may help to ensure quality of services	○ Would require the State to develop and implement procedures, standards and quality monitoring for a new set of providers.

Based on the findings, we, CFC's external evaluators, recommend that Vermont open its CFC HCBS service delivery system to additional non-medical providers. If the expansion is carefully and deliberately implemented, access and choice will be expanded and enhanced, costs will be controlled and quality will be maintained or improved.

Specifically, we recommend that Vermont adopt a phased-in approach to the expansion to non-medical providers with the following components:

- Open up the CFC market to non-medical providers, thereby removing the incomplete geographic monopoly of Home Health Agencies as a mechanism for providing HCBS services to CFC participants. Over time, allow transition of Personal Care Attendant (PCA) and homemaker services to non-medical providers, based on participant choice. As part of this expansion, current Home Health Agencies (HHAs) could elect to create separate non-medical provider entities of their own.
- Develop certification criteria and/or processes for any non-medical organization which would like to provide Home and Community-Based Services to CFC participants. This process could specify a number, small at first, of non-medical providers to be added during a given time period to ensure a deliberate and incremental

approach, allowing for fine-tuning as additional non-medical providers become certified. As part of the certification, develop criteria and a process by which non-medical providers enroll CFC participants.
- Maintain current case management services with the Home Health Agencies and Area Agencies on Aging.

Since the expansion of CFC providers will result in systemic changes, DAIL should use a 2-year statewide phase-in process. This phase-in process can be implemented with the following structural changes:

1. Open the CFC market non-medical providers (including HHA-organized non-medical entities) by eliminating the incomplete geographic monopoly of Home Health Agencies and allowing non-medical providers to qualify to provide PCA, homemaker, Respite and Companion services. Vermont should pay close attention to homemaker services as participants with these services seem prime "beneficiaries" of the expansion.
2. Revise CFC regulations to include non-medical providers, ensuring a thorough regular certification process to qualify and monitor non-medical providers.
3. Develop and/or revise materials to help participants understand and choose among the variety of settings and types of providers, based on the current "How to Choose a Case Manager" brochure and "Choices for Care Long-Term Care Options" brochure. DAIL can contribute to informed choice by crafting a list of easily understood questions to aid participants in selecting service settings, service models, and service providers.
4. Work with participants, surrogates, providers, direct service workers and State officials to develop a set of recommended minimum skills and knowledge competencies for PCA workers (Paraprofessional Healthcare Institute, 2004). While required training for direct service workers is controversial to some stakeholders, Vermont may decide to develop a training curriculum for its direct service workers.
5. Assess the impact of the expansion on the following:
    - Participants through use of the current annual consumer satisfaction survey measuring access, choice and quality with a specific module of questions for participants who use non-medical providers.
    - Participants and providers through ongoing quality reviews and provider monitoring including complaints
    - Providers of personal care, respite care, companion care, and homemaker services through annual reports of financial status including revenues, expenses, fund balance and worker status including full/part-time workers, rate of turnover, wages and trainings
    - CFC outcomes and performance through evaluation measures related to enrollment, costs, service quality, and service utilization.

If Vermont implements these steps in a phased approach, DAIL and CFC stakeholders can fine-tune the details of a system which best achieves the goals of CFC. All of the research suggests that this type of service delivery system, which allows for a mix of settings, options and providers including non-medical providers, will benefit participants, their families, providers, taxpayers and the State.

Introduction

Nationally, the provision of Home and Community-Based Services (HCBS) has changed. Over the years, Vermont's delivery system has also evolved to meet the long-term support needs of older adults and individuals with disabilities. Today, as the State confronts current and pending Federal and local health care changes and State fiscal limitations and health reform efforts in Vermont, a legislative mandate requires the examination of the role of non-medical providers within the Choices for Care (CFC) waiver. In the 2011 Vermont legislative session, Act 63 Sec. E. 300 (c) directed the Commissioner of DAIL to:

> Report to the House and Senate Committees on Appropriations, the House Committee on Human Services, and the Senate Committee on Health and Welfare by January 15, 2012 with recommendations regarding the scope of providers that the department may contract with to provide services under the CFC waiver. The recommendations shall be made in consultation with Home Health Agencies and other partner organizations and shall consider, among other things: the relative impacts on provider cost structure of State assessments and requirements; whether a lack of access by patients [sic] to the services justifies expanding the scope of providers; whether contracting with additional providers will affect the ability of patients [sic] to access CFC services; and whether CFC services should be removed from being considered "designated" Home Health Agency services.

Within this context, non-medical providers are defined as for-profit or not-for-profit organizations that recruit, hire, train and schedule workers to provide Personal Care Attendant (PCA), respite, companion and homemaker services. In Vermont, currently, non-medical providers work primarily with private pay clients and some Flexible Choices participants. Typically, they provide services 24 hours a day, 7 days a week and ensure backup workers are available in case a scheduled worker is unable to show up. These providers are not part of the CFC designated provider network. They are not Home Health Agencies and do not provide medical services.

For the purposes of this report, we use the following definitions of services, as these services would be provided as part of an expansion:

- Personal Care Attendant services (including Respite and Companion services): "The tasks of a Personal Care Attendant include assisting with the Activities of Daily Living such as dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home, and eating. Respite care means relief from caregiving and supervision for primary caregivers. Companion care means supervision and socialization of individuals who are unable to care for themselves, as required by the needs of the individual (e.g. protective supervision, assistance with transportation, recreation, etc.)" (CFC 1115 Long-term Care Medicaid Waiver Regulations, 2009).
- Homemaker services: "The tasks of a homemaker are home-based services such as shopping, cleaning, and laundry provided to help people live at home in a healthy and safe environment" (CFC 1115 Long-term Care Medicaid Waiver Regulations, 2009).

Purpose of Report

In response to the legislative directive described above, this report analyzes the possible addition of non-medical CFC HCBS providers in terms of access, choice, cost and financial impact, and outcomes and quality. This report is part of a series of independent reviews of policies and procedures related to the implementation of Vermont's

Choices for Care (CFC) waiver. These policy briefs and reports examine key policy questions and provide an external perspective to help DAIL ensure that policies and procedures are as effective as they can be in supporting CFC goals.

This report describes the advantages, benefits, disadvantages and challenges of adding non-medical providers to the current list of CFC service providers. The report concludes with a set of recommendations for Vermont to consider to make sure that any action to add non-medical providers ensures access, choice and quality, while addressing costs and financial impacts.

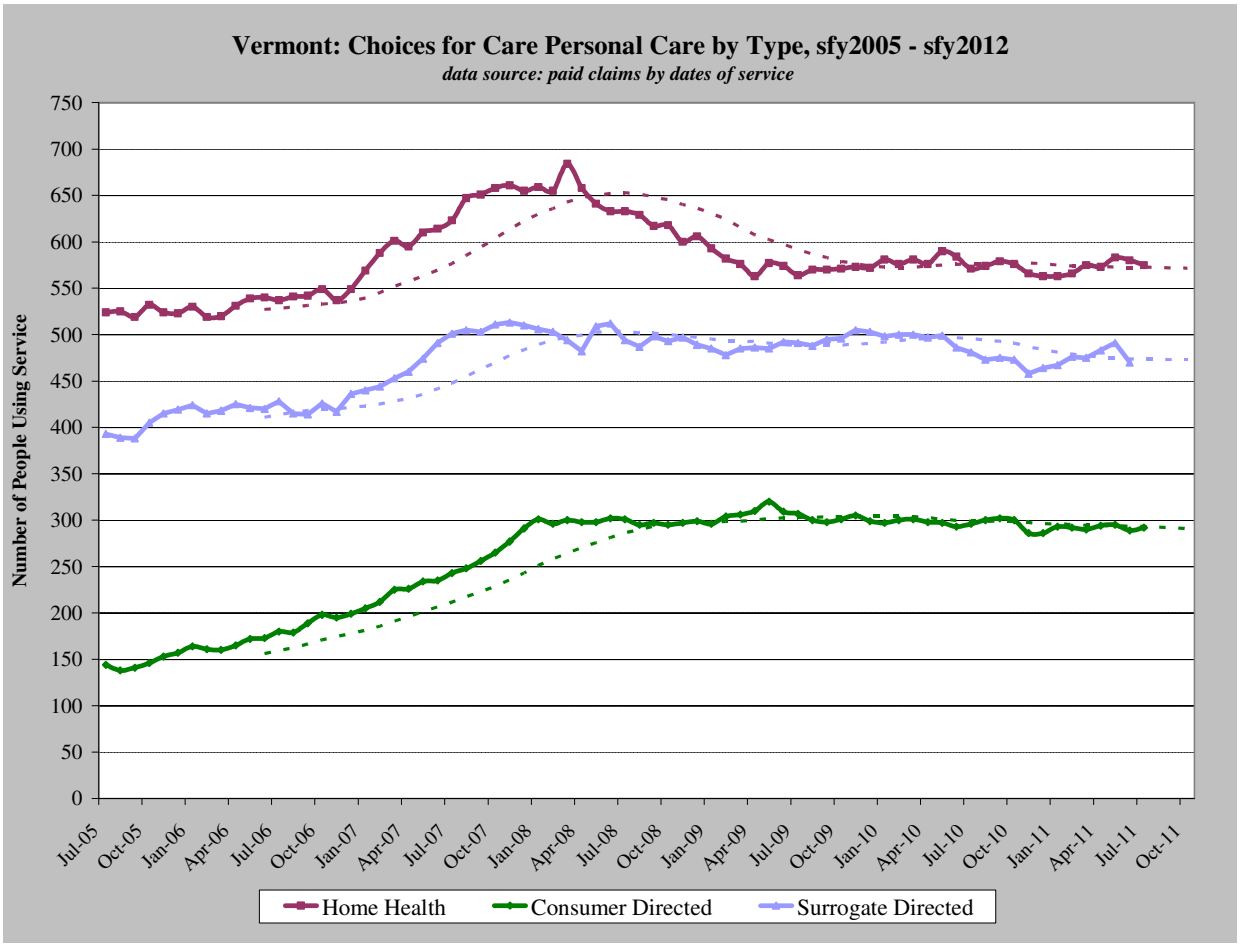
Background on Choices for Care (CFC) Waiver

In October 2005, Vermont implemented Choices for Care, an 1115 Waiver Demonstration program. The purpose of the program was to ensure that older adults and people with disabilities have access to long-term support services in a setting of their choice from institutional to community. To achieve this goal, CFC encompassed the entire continuum of long-term support services. Today, CFC includes Home and Community-Based Services, Enhanced Residential Care (ERC), nursing facilities, Consumer-directed care, Surrogate-directed care, a "cash and counseling" model through Flexible Choices, Program for All-inclusive Care for the Elderly (PACE), and Home Health Agency services.

To fully support the provision of CFC services, a three-tiered system was established in which individuals with long-term care needs were identified as: Highest Needs, High Needs or Moderate Needs. Individuals identified as Highest Needs are guaranteed services. Individuals who are identified as High Needs may face a delay in access to services depending on the availability of funding, and may be placed on an applicant (waiting) list. Those individuals who are identified as Moderate Needs are below the level of care that would require nursing facility placement, may not meet the financial criteria for Medicaid long-term support services, and can receive limited homemaker services, adult day services and case management. Similar to the High Needs group, Moderate Needs individuals may also be placed on an applicant (waiting) list (Bruner-Canhoto and Cumings, 2011). Therefore, when thinking about the services non-medical providers may offer to CFC participants, personal care services and homemaker services would be available to High and Highest Needs participants, while homemaker services would be available to Moderate Needs participants.

For those individuals receiving services in the community and not in ERCs or nursing facilities, there are several service options: Consumer-directed/Surrogate-directed, Flexible Choices or Agency. For participants who choose to direct their own services or have a surrogate direct services, the fiscal management company, ARIS Solutions (ARIS), conducts background checks for all workers and manages the payroll. Another option is Flexible Choices. Participants who select the Flexible Choice option receive a budget which they can then use to purchase the services they need; non-medical providers are one service which Flexible Choices participants may purchase. As with the Consumer-directed/Surrogate-directed option, ARIS manages the payroll and conducts background checks of workers employed through Flexible Choices. The third option is to select an agency provider. Working with a case manager either from an Area Agency on Aging (AAA) or a Home Health Agency (HHA), a service plan related to PCA and homemaker services is developed. The service plan is then used by the HHA to provide services to the participant.

In October 2011, enrollment was greatest for the Agency model, followed by Surrogate-directed and Consumer-directed (see graph below from the Medicaid paid claims by month, October 2011). While these three options had enrollments from under 300 to a little under 600, Flexible Choices had a lower enrollment of around 90 participants.



(Source: DAIL, Medicaid paid claims by month, October 2011)

Well over half of personal care is provided through options other than the Home Health Agency. Furthermore, these enrollment numbers highlight that the expansion of CFC service options has directly and demonstrably contributed to the State's success in increasing the number of individuals using HCBS and decreasing the number of individuals using nursing facilities.

Methods

In this report, we aim to understand

1) advantages and benefits of the addition of non-medical providers
2) disadvantages and challenges of the addition of non-medical providers.

Based on these benefits and challenges, we then present recommendations for Vermont on the possible addition of non-medical providers.

We relied on four different strategies to gather data and reach our conclusions.

1. We conducted literature reviews and environmental scans to obtain a general overview of non-medical providers within the national Home and Community-Based Services context.
2. We conducted telephone interviews with over sixty key informants/stakeholders. Stakeholders included those specifically named by the legislative directive such as the executive directors and staff of Home Health Agencies. Other individual stakeholders and groups such as the executive directors and staff of Area Agencies on Aging, relevant State agency staff, accountants from the State and independent proprietors, case managers, discharge planners, non-medical providers, and direct service workers were interviewed. See Resources for a list of all entities and groups interviewed.
3. We worked with Market Decisions to add questions about non-medical providers to its independent survey of Vermont's Long-Term Care Consumers. This annual survey was administered in October and November 2011 and included additional questions for Flexible Choices participants, Personal Care (Agency or Consumer-directed/Surrogate-directed) participants and homemaker recipients that allowed us to gain some understanding about attitudes and opinions of participants on this topic. Fifty-seven CFC Flexible Choices, 323 CFC Personal Care and 276 homemaker participants completed the survey.
4. We reviewed documents from four other states (Maine, Massachusetts, New Hampshire and Montana) that have made the types of changes that Vermont is contemplating. We chose these states, in collaboration with DAIL, as representative of population size, region of the country and/or rural/urban mix similar to Vermont.

The following topic areas guided our reviews and interviews:

- Access: factors which may impact a participant's enrollment and use of CFC Home and Community-based services.
- Choice: current supports and/or obstacles which impact a participant's configuration of services which best meet his/her needs.
- Cost and financial impact: perspectives on any potential cost the addition of new non-medical providers may have within the service delivery system including, but not limited to, the role State and Federal governments and providers may have on the cost of HCBS services and the financial impact the addition of non-medical providers may have on the State and current HCBS providers.
- Quality and outcomes: the overall quality of CFC HCBS services and outcomes as well as methods to evaluate quality and outcomes for participants and the overall system.

We first present an overview of long-term care service delivery in Vermont with a focus on Choices for Care. We then summarize the results of all data collection in terms of access, choice, cost/financial impact and quality/outcomes. Additionally, we include a summary table to consolidate the benefits and challenges associated with the addition of non-medical providers. We then conclude with recommendations based on our objective analysis of these benefits and challenges for the potential transition to a service delivery system which includes non-medical providers.

Overview

Nationally, the long-term support service system has changed with growing emphasis on supporting people with services in the setting which they prefer. These changes are reinforced by an increasingly accepted philosophy which recognizes the person as the driver of services. The 1999 Olmstead decision further supported this shift with its requirements that people with disabilities have the right to live in the least restrictive setting (States in Action newsletter, The Commonwealth Fund, 2010).

Throughout the history of the long-term support system, states have employed different mechanisms to ensure that services are available across the spectrum of care from institutions to community settings. As the system has become more person-centered and driven, a greater focus on home and community-based settings has emerged. There are several surveys which report that elders and adults with disabilities, when asked, express a preference to live in the community. In a 2007 Henry J. Kaiser Family Foundation study, 81% of older adults stated that they would prefer to receive services in their home (Weiner and Anderson, 2007). In Vermont, 65% of AARP members responding to a survey stated that they would prefer to receive long-term services and supports in their home, with another 18% preferring assisted living or residential care (AARP, 2010). Vermont's Choices for Care (CFC) program, as explained above, is a tangible expression of the changing long-term supports system with its emphasis on community settings and choice. It is within this context that the issue of adding non-medical providers is presented.

Currently, like 16 other states and the District of Columbia, Vermont has a Certificate of Need process for Home Health Agencies (Research Planning Consultants, 2011). Even though there are other organizations which contribute to the provision of CFC services and there is one HHA which can serve CFC participants statewide, Vermont has structured its system in such a way that one HHA serves a particular geographic area. Thirteen of the Home Health Agencies are Visiting Nurses Associations (VNA). Each VNA has a defined geographic area for which it is responsible; in essence, this is a somewhat incomplete geographic monopoly in which participants may not have much actual choice of provider.

As a result of the limited number of HHAs and the incomplete geographic monopoly of HHAs, stakeholders stated that CFC participants did not always receive the full complement of services identified in their service plan. Although assertions were based on anecdotal experiences, it was suggested that some participants used the Consumer-Directed or Surrogate-Directed option (as opposed to the Agency model) because these options and Flexible Choices were their only alternatives to ensure that their service needs were met. The mother of one CFC participant observed that her son decided to hire someone he knew to be his PCA because the people the agency sent sometimes didn't show up.

The options for agency providers expanded in 2009 when a Certificate of Need was granted to Bayada Professional Nurses Services, a for-profit Home Health Agency, to offer services across the State. Additionally, there are other organizations such as two PACE programs, the Flexible Choices program and its fiscal intermediary (ARIS), and adult day centers, which are part of the provider network and can provide participants living in their homes (as opposed to ERC) with a wider spectrum of choice in terms of services and settings. If non-medical providers are added to CFC, their role as providers of personal care and homemaker services would be most similar to Home Health Agencies as CFC providers.

Today, depending on a participant's location, an individual who selects an agency provider can now choose to receive services from a non-profit HHA, Bayada and/or PACE (we do not include Flexible Choices participants because they represent a different service option and they can use their budget to pay for non-medical providers today). In order to fully meet their service needs, participants may combine the use of these agencies. Yet, based on information gained from the interviews with stakeholders, the ability of participants to actually get approved services varies across the State. Many interviewees commented that it is difficult to find workers in rural areas. Interviewees noted that in the city, it is often possible for the HHA to schedule one PCA or homemaker to visit several participants in a morning. However, in rural areas, where a PCA or a homemaker has to drive long distances to get to

participants' homes, schedules are often thrown off; resulting in people not receiving services at the time the worker was scheduled to be there. It is clear that people in different parts of the State have varying coverage and access to services. One interviewee talked about a HHA that does not provide any PCA services after 8:00 PM, even though participants in the area require PCA services after that time. These stories illustrate circumstances in which services and access to services were below expected standards.

Today, in Vermont, several non-medical providers already provide personal care and homemaker services to private pay individuals. These private pay individuals (or their families) either pay out-of-pocket or use long-term care insurance benefits for services in their home. Medicaid, including CFC (other than Flexible Choices), does not pay for these services provided by non-medical providers. The exception is that participants who use Flexible Choices can choose to purchase PCA and homemaker services from non-medical providers. One provider shared an example of their 2012 rates (not wages), based on the total hours scheduled for a week:

3 hours per week is $19.00 per hour
9 – 20 hours a week is $18.00
33 – 55 hours a week is $16.00 per hour

Maine, Massachusetts, New Hampshire and Montana have all changed their service delivery system over the years. Montana provides one example of changes to the system. In 1977, Montana began with all PCA workers as county employees (Doty, Kasper and Lipvak, 1996). Today, Montana contracts with 28 agencies to provide independent case management services. Montana offers a consumer-directed program and an agency-based program where enrolled agency providers manage the services on behalf of the person. Echoing Vermont's CFC enrollment figures, in 2010, 54% of Montana's consumers were using the consumer-directed option (Montana Department of Health and Human Services, 2011).

Under the Romney administration, Massachusetts embarked on a reorganization of its state agencies. As part of this effort, the Department of Medicaid Assistance became part of the Health and Human Services Secretariat with the Office of Long-term Support Services linked to the Executive Office of Elder Affairs. Currently, Massachusetts contracts with personal care management agencies to conduct the assessment of elders and individuals with disabilities to determine their PCA service hours. There are three agencies that provide fiscal intermediary services for participants who self-direct their PCA services. From Calendar Year 2006 –2009, the number of members using PCA services increased by 9% annually (Unpublished Presentation, 2010).

Maine also consolidated its long-term support services agencies by combining services provided by the Department of Mental Health and the Department of Health and Human Services (Bubar, Ring, Yoe, Turyn et al, 2009). Maine contracts with one agency, Goold Health Systems, which completes an assessment to determine an individual's eligibility for home and community-based services. The assessment is open to everyone who feels that he/she may need some assistance. For many years, Maine's long-term support service was aimed at deinstitutionalization. However, since the late 1990s, its system has focused on diversion (Bubar et al, 2009). The state contracts with one Area Agency on Aging to manage the providers of HCBS. Similar to other states, Maine consumers can choose to either consumer-direct their services or to receive services from an agency.

As states have reorganized their service delivery system, each state confronted many of the issues Vermont is now facing. Each state experienced growing pains. However, each state developed a system that is designed to respond to the needs of its participants, their families, the providers and the workers.

Findings

This section presents the information gained from the data collection and provides a context for analysis. Findings include the summarized responses of the interviewed stakeholders, analysis of consumer survey questions, and reviews of State policies and related documents.

Access

The addition of non-medical providers, by increasing the number of service providers, would increase access. However, there are a few caveats to this conclusion. Certainly, interviewees observed that the addition of non-medical providers would increase access to services. Their reasoning was often that with the increased availability of organizations which can provide PCA and homemaker services, participants would have a greater likelihood of getting the services they need. In addition to "simple" access, some interviewees commented that one benefit of adding non-medical providers may be that non-medical providers would be willing to do things differently. In one case, the interviewee explained that "differently" meant providing transportation, allotting time to accompany the participant to a hair appointment, and going for a walk. Also, most non-medical providers typically offer their services 24 hours a day 7 days a week, and guarantee that backup is available if a scheduled worker is not going to show up.

As will be seen in the Cost and Financial section below, several Home Health Agencies suggested that if non-medical providers were allowed in the market, they may be forced by financial concerns to make a business decision to stop providing CFC services. Therefore, potentially, access, as defined by total number of providers, could remain the same. If non-medical providers were added, it seems that there is little possibility of access actually declining, if one supposes that non-medical providers entering the CFC market could replace the service capacity of any HHAs that choose to leave. In fact, HHAs may not be able to simply leave the market. According to Vermont statute, the Commissioner determines whether a HHA no longer provides services (Title 33: Human Services, Chapter 63: Home Care Programs, 33 V.S.A. § 6304).

When asked about possible challenges participants may encounter, a few interviewees raised the issue that with more providers, some participants may be overwhelmed by the increasing complexity of choices. Some interviewees commented that often individuals have no experience in choosing services and, when presented with a wide range of service providers, may be unable to determine which one to select. All of the states we reviewed are using the internet as a resource to aid individuals and their families in the selection of Home Health Agencies. On the states' websites, information describing the role of a provider agency, the rights and responsibilities of individuals, and links to needed forms and manuals are available. Additionally, people can access a state's Aging and Disability Resource Center (ADRC) for information and assistance. One state which we did not examine in detail, Colorado, has a brochure "Finding a Home Health Agency" which lists questions a person can use in selecting a provider.

In the Market Decisions survey (Robertson, Maurice and Madden, 2011), participants (Personal Care recipients through agency/self/surrogate direction; Flexible Choices; and homemaker) themselves noted that adding providers would increase their access to specific types of services. Between 43%-52% of participants strongly agreed or

agreed with the statement that having more providers who offer the respective service would allow them to better meet their needs. About one-third of participants strongly disagreed or disagreed with the statement, showing that participants are not a uniform group with the same beliefs and attitudes. In terms of access, there was similar support for the idea that adding new providers would improve participants' ability to have services where and when they need them, with 47%-56% strongly agreeing or agreeing with that statement. There were a smaller percentage of participants who strongly disagreed or disagreed with this statement (between 21% and 31%). The slightly higher agreement and similar lower disagreement to this second statement of access highlights the fact that CFC providers already do a good job making sure participants receive services; however, many participants see the advantage of more providers in terms of improving access to services.

These results also show that the three types of participants experience services and access to services differently, a theme that is borne out in the other focus areas and has implications for policy recommendations. For example, a higher percentage of homemaker participants supported the idea that adding new providers would improve their ability to have services where and when they need them.

Statement	Personal Care	Flexible Choices	homemaker
Having more providers who offer [Type of services] would allow me to better meet my needs.			
• Strongly agree or agree	52%	50%	43%
• Strongly disagree or disagree	31%	33%	39%
Adding new providers of [Type of Services] would improve my ability to have services where and when I need them.			
• Strongly agree or agree	47%	53%	56%
• Strongly disagree or disagree	31%	28%	21%

*Percentages in all tables with survey responses are weighted (Robertson, Maurice and Madden, 2011)

Adding non-medical providers would provide improve access to services, a theme echoed through interviews and surveys.

Choice

There is little doubt that the addition of non-medical providers would expand choice. Interviewees agreed that non-medical providers could improve choice for participants in several areas including setting, schedule and provider choice. At the same time, many interviewees noted that there are already a lot of opportunities within the CFC system to support choices.

Currently, participants who choose to receive services in their own home can choose whether to receive services from an agency, Consumer-directed or Surrogate-directed services, Flexible Choices, PACE and/or an Adult Day Center. Some of the stakeholders also noted that the participant sometimes has the choice to accept or to reject a specific worker, although this choice may not be universal within every option and may not be known to all participants. However, if a participant selects to receive services from an agency and is unable to get services because staff is not available or because the agency is unable to meet the hours, then there's no real choice.

Similarly, if a participant chooses to either consumer-direct/surrogate-direct or to use the Flexible Choice option and is unable to hire a PCA from the Vermont Registry or other recruitment avenues, then choice is not meaningful.

Interviewees cited several instances of people who were approved for hours of service but did not actually receive all of those hours. This is an issue of both choice and access. One interviewee told of a coworker who was unable to participate in any activities in the evening because he had to be home by 6:00 PM to be assisted into bed because that was the time his PCA was scheduled to show up. Other interviewees talked about a participant's PCAs who did not show up, resulting in a participant who had to stay in bed until someone did show up. One interviewee shared an instance when her father-in-law's PCA did not show up; as a result, she had to help him, although he did not want to be assisted in using the bathroom by his daughter-in-law.

Fundamentally, stakeholders acknowledged that in many areas of the State, participants choosing to receive services through an agency are effectively limited to the choice of just one CFC agency provider. Even though other options such as PACE and Bayada have emerged and are available in many parts of the State or statewide, the perception of a majority of the interviewees was that these options are not always completely known or available to all participants.

Within the CFC system, case management can be provided either by an Area Agency on Aging (AAA) or HHA. Because the case manager is often an employee of the HHA, there was a perception expressed by some interviewees that there may be some hesitancy or reluctance to fully present all of the available options to a participant. Several interviewees raised the issue of the potential conflict of interest for HHA case managers, whereby HHA case managers would encourage HHA services without adequately describing other options. If a participant chooses another option, the HHA may lose that individual as a client. One interviewee commented that "Once someone is discharged, there is no sharing. No one here plays in the same sand box. Even if the service would be more appropriate that the person goes to another service provider, if the VNA or the AAA has that person in their service network, they don't leave that network."

Many interviewees observed that the current agency delivery system can limit choice. If there is only one organization providing services in the area or a case management agency limits access to information about other options, then the option to use another agency provider does not really exist. Some participants faced with this limitation will select to use Consumer-directed/Surrogate-directed, Flexible Choices, or PACE.

In effect, choice is dependent not only on the number of options available but also on the information provided to participants about those options. With the addition of non-medical providers, there would be an increase in the number of options available to participants, about which people would need to be informed. As we noted in the Access section, this may seem overwhelming to some individuals.

Participants' responses were mixed when asked about choice related to services. In all choice questions, people with homemaker services were less likely to agree that they were able to exercise choice than people with Personal Care or Flexible Choices. While 82% of Personal Care participants and 85% of Flexible Choices participants strongly agreed or agreed that they were able to choose their service, only 60% of homemaker participants strongly agreed or agreed with that statement. In fact, for all statements of choice, as compared to Personal Care or Flexible Choices participants, a much lower percentage of homemaker participants strongly agreed or agreed with these statements, while a higher percentage of homemaker participants strongly disagreed or disagreed with these statements.

Statement	Personal Care	Flexible Choices	homemaker
I was able to choose my [Type of services].			
• Strongly agree or agree	82%	85%	60%
• Strongly disagree or disagree	8%	7%	19%
I was able to choose the provider of my [Type of services].			
• Strongly agree or agree	73%	81%	39%
• Strongly disagree or disagree	13%	10%	43%
I was able to choose the scheduling of [Type of Services] that meets my needs.			
• Strongly agree or agree	78%	92%	65%
• Strongly disagree or disagree	11%	4%	22%
I was able to select my [Type of services] provider from a variety of providers.			
• Strongly agree or agree	59%	65%	28%
• Strongly disagree or disagree	24%	19%	55%

These homemaker participant responses, together with the strong agreement for choice statements by the other participant groups, point to a perceived lack of choice for homemaker participants. Participants who use Personal Care and Flexible Choices have several choices including which one of these two services to use and which model of services (Consumer-directed/Surrogate-directed/Agency) to use if Personal Care is chosen. This highlights a theme that will be considered in the recommendations: what can or should choice look like for people who use homemaker services?

It is also noteworthy that even for the two other groups of participants (people receiving CFC Personal Care services or people who receive CFC services through Flexible Choices), there was a small minority who did not feel that they had choice. Thirteen percent of Personal Care participants strongly disagreed or disagreed that they were able to choose their provider, while 11% strongly disagreed or disagreed that they had scheduling choice. Flexible Choices participants were a little less likely to strongly disagree or disagree with those two statements, possibly because of the focus of the person driving the process that is inherent in Flexible Choices. If we look at these results with the Access survey results (between 47%-56% of participants noted that adding new providers would improve their ability to access services where and when they need them), adding non-medical providers would appear to address both choice and access for many homemaker participants and some Personal Care and Flexible Choices participants.

The survey results and the interviews suggest that some people may currently choose consumer/surrogate options because these are their ONLY alternative to Home Health Agency services. If they had other agency choices (i.e., non-medical providers), they might choose those agencies. The percentage of these individuals who may elect to use agency services if non-medical providers were available is not yet fully known. During the interviews, participants offered several perspectives. One person commented that even with the addition of non-medical providers, he would continue to use his wife as a caregiver because her assistance helps him to accomplish some very personal tasks. Another individual remarked that with the inclusion of non-medical providers, people with disabilities could have workers who better fit their schedule enabling them to be employed. Both perspectives appear to be true and some

percentage of participants can be expected to choose to use non-medical provider services if they do become available.

The inclusion of non-medical providers would increase choice for all services, especially for people who use homemaker services who currently have no other options.

Cost and Financial Impact

Nationwide, the commitment to Home and Community-Based Services is driven, not only by people's desire to be served in their own homes and communities, but also by the reality that aiding people to remain in the community is often less expensive than paying for institutional care. National average rates for a semi-private room increased by 3.7% from $191 daily or $69,715 annually in 2008, to $198 daily or $72,270 annually in 2009 (The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, 2011). According to the MetLife report, for a semi-private room in 2011 in Vermont, the Low/Average/High costs was $155, $235, and $285, respectively (2011 MetLife Survey, 2011). Based on its 2008 report, State of the Caregiving Industry, the National Private Duty Association found that 20 hours of companionship service a week costs approximately $1,500 a month or an annual cost of $18,000.

The below CFC rates paid to HHAs include the amount of worker wages and administrative costs, whereas the below CFC rate paid to Consumer-directed/Surrogate-directed workers is the wage amount. ARIS is paid separately for its fiscal intermediary role. As of August 2011, DAIL pays Home Health Agencies the following hourly rates:

Service	HHA
PCA	$26.88
Respite or Companion	$21.48
Homemaker	$19.32

As of August 2011, DAIL (DAIL/DDAS Services: Medicaid Claims Codes and Reimbursement Rates, version 8.1.11) established the following actual wage amounts for Consumer-directed/Surrogate-directed workers:

Service	Consumer-directed/Surrogate-directed
PCA	$10.14
Respite or Companion	$8.62
Homemaker	N/A

These wage amounts compare favorably to national averages of between $8.92 and $9.69 an hour (State of Care Giving Survey conducted by the NPDA, 2009).

Based on our interview with non-medical providers in Vermont, we learned that agencies have varied payment/rate plans (see page 9 for one example). The 2011 MetLife report also found that in Vermont, the hourly rate (not wages) for PCA/Home Aides and homemaker services for licensed and unlicensed agencies in 2011 were:

Service	Low	Average	High
PCA/Home Aide	$20.00	$24.00	$30.00
homemaker	$15.00	$20.00	$22.00

Some non-medical provider agencies pay overtime and shift differential rates for workers who work overnight and weekends. Other agencies use the Federal Fair Standards Act which equates workers designated as "companions" with babysitters, exempting their employers from paying a minimum wage and overtime requirements. It is anticipated that this exemption will no longer exist because President Obama's proposal to redefine the Federal law which will require that PCAs and homemakers hired by a staffing agency are paid a minimum wage and overtime will be required (HR Hero.com, 2011). Based on interviews with non-medical providers, this change will only impact a few of the current non-medical providers whose wages and rates may increase to comply with the new requirements.

Some interviewees suggested that one reason for the cost differential between HHAs and non-medical providers is that non-medical providers are not required by the State or Federal government to have a Registered Nurse oversee the work of PCA and homemaker staff and as a result, their service costs is less. Other interviewees suggested that the difference in cost is due to the fact that the non-medical providers operate in a competitive market without HHA agency requirements and other infrastructure costs and that their actual cost is less. As long as the State does not establish a system which will require licensed medical oversight of services provided by non-medical providers, it is reasonable and possible to negotiate a reimbursement rate which is lower than the current Home Health Agency rate. It would seem predictable that such a rate would be an amount between the existing Consumer-directed/Surrogate-directed rates and the HHA rate.

Nationally, with the increasing number of adults who are 65 years and older as well as the rising prevalence of disability in younger populations, the Department of Labor predicts that the direct service worker field will be one of the fastest growing employment areas. Based on the 2000 Census data, it was projected that by 2030, in Vermont, out of a total population of 711,867, individuals 65 years and older will be 173,940 or 24% of the population (U.S. Census Bureau, Population Division Interim Release, 2005). Because the Vermont population reflects the national trend (Wasserman, 2006), we can assert that the demand for direct service workers will likely continue to increase.

The direct service worker field is one of the fastest growing in the United States; "according to the Vermont Department of Labor, Personal and Homecare aides will be the first and fourth fastest growing occupations between 2006 and 2016" (PHI, State Facts, Vermont's Direct-Care Workforce, retrieved from www.phinational.org). However, many direct service workers continue to earn wages which keep them and their families at the poverty line. As the Chart Book on Wages for Personal Care Aides 2000 – 2010 (2010) indicated, in 2010, the nominal hourly wage in Vermont for a PCA was $10.40, an amount which is below the livable wage in Vermont.

2010 Livable Wage Rates in Vermont

Family Type	Urban	Rural
Single person	$16.82	$15.23
Single-parent with one child	$26.36	$23.23
Single parent with 2 children	$31.98	$28.36
2 adults with no children	$12.55	$11.79
2 adults with children(one wage earner)	$30.00	$28.78
2 adults with 2 children(2 wage earners)	$19.62	$18.38

Source: Basic Needs Budget and the Livable Wage, 2011

With the expansion of CFC providers to include non-medical providers, the demand for workers would increase. This could mean an increase in demand for hours from current workers and/or an increase in demand for new workers. This could also mean that wages for workers may increase because there now would be more competition for workers among an expanded group of employers.

Numerous studies indicate that many elders and people with disabilities use non-medical services to remain in their homes. These studies also show that there has been a chronic shortage of workers to provide services and that with the demand for services predicted to increase, the gap in supply will persist. Although it is beyond the scope of this report to delve into issues of recruitment and retention of workers, our review of the literature suggests that it is an area in which DAIL should play an active role.

For the purpose of this report, it is most important to recognize that a review of literature shows that all states are contending with the demand for workers outstripping the available supply of workers. The National Clearing House on the Direct Care Workforce has gathered extensive research demonstrating states' response. Beginning in the late 1990s, Maine increased wages and benefits. More recently, Maine launched an initiative to assist Home Health Agencies to provide health care benefits through insurance for workers. Montana, using grant support from the Federal government, instituted a health insurance program for its direct care workers. In Massachusetts, state law M.G.L. C 18G Sec. C 28-33 established a PCA Workforce Quality Home Care Workforce Council. The PCA Council has nine members, the majority of whom are PCA consumers. The purpose of the PCA Council is to: create and maintain a PCA registry, recruit new PCAs to work, bargain with the Union representing PCAs on wages and benefits and help inform consumers and PCAS about opportunities for PCAs to receive additional training (PCA Council Brochure).

As noted previously, some Vermont Home Health Agencies have argued that if there is competition within the service delivery system they will most likely have to stop providing CFC services. This observation was made several times during the stakeholder interviews. However, at least for some agencies, as one interviewee noted, "The CFC program is a pipeline business for VNAs". A CFC participant may begin with PCA and homemaker services and over time require skilled nursing services and even end of life hospice care, all services which a VNA provides. Therefore, it may be suggested that even if VNAs lose money providing CFC services to some participants, because these participants have other service needs, the VNAs may find it useful to continue to provide CFC services. It should again be noted that the Home Health Agencies under the statute designating the Home Health Agency cannot reduce provision of services without the Commissioner determining that the reduction is necessary. We also note that

under HHA cost allocation, ending CFC services would mean that some costs that are currently covered by CFC revenues would have to be covered by the remaining revenue sources. This could result in losses in those programs and cost centers that currently operate with surpluses.

Alternatively, another HHA response to the expansion of CFC providers could be the creation of business entities that are themselves non-medical providers. It appears that under existing HHA regulations, Vermont can allow HHAs to create separate entities that operate under the same conditions as other non-medical providers. By doing this, they would not have to adhere to the HHA certification requirements and would be able to compete with other non-medical providers on a "level playing field".

The cost of including non-medical providers includes two elements: movement from higher cost Home Health Agency services to moderate cost non-medical provider services, and movement from lower cost Consumer and Surrogate-directed services to moderate cost non-medical provider services. First, non-medical providers will contribute to lower costs because non-medical providers would be reimbursed at a lower rate than HHAs (see rates on pages 9, 14 and 15). To the extent that Home Health Agency services are replaced by non-medical provider services, costs will be reduced. Presently, non-medical providers charge the individuals they work with less than a Home Health Agency is reimbursed for an hour of PCA services (Interview with Non-medical providers, 2011; see cost chart on page 9). The 2008 Genworth Financial report on the cost of care survey concluded that due to competition within the private duty (including non-medical provider) market, that in the four previous years, there was only a 1% increase in the cost of services. Even though we do not know the specific increase in Vermont, one can extrapolate that because the private duty/non-medical provider market is competitive, the rate of service cost increase is also small. Secondly, non-medical providers will contribute to higher costs because non-medical providers would be reimbursed at a higher rate than Consumer-directed/Surrogate-directed services. We can expect some people to choose non-medical provider over Consumer and Surrogate-directed services because some participants have chosen this option as the only alternative to the agency model.

Participants were asked about the impact of adding new providers on the cost-effectiveness of their services. There was a low level of agreement with the statement about cost-effectiveness, with only 37% to 38% strongly agreeing or agreeing that adding new providers would improve the cost-effectiveness of services. It is also instructive to note that between 14% (Flexible Choices) and 29% (homemaker) of participants reported that they were "unsure" about this statement, so possibly it was more difficult for them to "judge" cost-effectiveness. Interestingly, more Flexible Choices participants, who manage their own budgets and could most realistically be expected to consider the cost effectiveness given that they can really see the cost, strongly disagreed or disagreed with the statement. Again, homemaker participants seemed most supportive (both in terms of a higher agreement percentage and a lower disagreement percentage) of the idea of new providers.

Statement	Personal Care	Flexible Choices	homemaker
Adding new providers of [Type of services] would improve the cost-effectiveness of my services.			
• Strongly agree or agree	37%	37%	38%
• Strongly disagree or disagree	31%	34%	22%

The use of 'case rates' in Home and Community-Based Services, and "per member per month" rates contemplated in the Vermont Dual Eligible initiative, would both create incentives to use lower cost care. Although there may not be reductions in cost per se, if people use the Consumer-directed/Surrogate-directed option and non-medical providers, there may result a higher volume of services and better access with the available funding.

Given our analysis of the cost and financial impact perspective, adding new providers would have either a positive or neutral impact.

Quality

Quality of services, at the core, is about individual outcomes and experiences. In the Consumer survey, there was a low level of agreement with the idea that adding new providers would improve the quality of services. Equally important, there was a similar low level of disagreement with that statement. So, for some participants, quality does appear to be an important benefit or concern related to adding providers; for others, it is not an important benefit. Perhaps, this is because participants surveyed indicated that quality of services was already high with 97% of Personal Care participants, 91% of Flexible Choices participants and 90% of homemaker participants rating their services as either excellent or good.

Statement	Personal Care	Flexible Choices	homemaker
Adding new providers of [Type of Services] would improve the quality of my services.			
• Strongly agree or agree	40%	43%	47%
• Strongly disagree or disagree	36%	35%	26%

Echoing this theme of high quality, none of the interviewees stated that the current quality was poor. Instead, the majority of comments ranged from better than it was years ago to very good. Interviewees also agreed that it is important to have a system which provides quality services.

Interviewees raised concerns about the addition of non-medical providers and their potential impact on the quality of services. Concerns included issues of the competency of the workers, personal and financial safety of the participants, and the capacity of the State's oversight system to monitor and respond to problems associated with a new provider group. During the interviews, it became clear that some of the concerns and subsequent comments resulted from interviewees not always fully being aware of the functioning of other organizations. For example, some interviewees talked about the lack of background checks and training for workers from non-medical providers. However, when we interviewed non-medical providers, they stated that they do conduct background checks on workers and they do provide training and oversight of workers. There was also concern that those workers who are hired directly by participants or their surrogates lack any background checks, even though ARIS does conduct background checks on all workers hired by participants or their surrogates, a fact that appeared not to be known by several interviewees.

Over the years, training for PCAs has emerged as a controversial issue. For instance, Mathematica in its 2005 assessment of workers hired through the Cash and Counseling program found that there was no difference between workers who were trained and those who were not in terms of workers feeling prepared to meet expectations in helping consumers (2005, cited in Lewin Group, 2007). However, as part of the person-driven system, people have

fought for the right to train their own PCA workers. Also, as states have worked and continue to work to professionalize the PCA field, training is used to improve skills and to develop career options. Consequently, tensions have emerged among individuals, families, workers, providers, and states over the role of training.

The Federal government establishes training and licensing requirements for some direct service workers. However, the Federal government has not established any training requirements for PCA workers who work in the community. As a result, while a significant body of research which has been conducted examining the beneficial impact of training on direct care workers in institutional settings, less research exists on community-based workers.

The Paraprofessional Healthcare Institute in its 2004 Workforce Tools series wrote, "The advantages of ensuring that all workers have certain essential skill sets are numerous. First, if trained appropriately, workers have greater confidence and are more likely to stay on the job; second, workers with a core set of skills can more easily move from one setting to another, giving them greater flexibility and enlarging the labor pool for employers; and third, appropriate training enhances consumer safety while also instilling respect for consumers rights." The Longevity Center, in its 2008 nation-wide environmental scan of training and curriculum programs for caregivers, concluded that training positively contributes to workers having the skills and knowledge to work with individuals (Longevity Center, 2008).

One aspect of the person-driven service delivery system in Vermont is that individuals have the right and responsibility to directly train their workers. Home health agencies and non-medical providers also train their employees, even though there are no universal State requirements. As one interviewee states, "It's good business to have trained staff." New Hampshire's experiences may be instructive related to training. New Hampshire requires that anyone working as a PCA receives 10 hours of training. This may be an option for Vermont to ensure that all PCAs whether working for an agency or as an individual provider would possess some basic skills.

As Home and Community-Based Services in Vermont have increased, the State has realigned resources to ensure that quality is assessed and monitored. The Division of Disability and Aging Services (DDAS) conducts on-site service reviews of all CFC home- and community-based services (HCBS) agency providers, using standards that emphasize individual outcomes (O'Connor, 2009). In adding non-medical providers, DAIL should develop provider standards and build the capacity to monitor these agencies as well. This will require some additional staff resources.

Also related to quality, Vermont commissions an annual consumer satisfaction survey (Robertson, Maurice and Madden, 2011), completed by an independent entity that produces a report made available to the public. DAIL uses this survey to assess satisfaction, experiences and perspectives including areas of the CFC program that can be improved. This process does not preclude individual organizations from developing and implementing their own systems of quality assessment and improvement. As one respondent noted, "Sometimes it is going through the process of quality assessment that an organization is able to improve its quality of services".

The HHAs, because of their Medicare certification status, must adhere to federal quality guidelines. From the interview with non-medical providers and the Draft Documents for recommended standards they provided to us, current Vermont non-medical providers have been developing guidelines for their services. As DAIL contemplates the inclusion of non-medical providers into the CFC service delivery system, DAIL should develop quality requirements which best meets the needs of the CFC program.

Summary of Benefits and Challenges of Addition

Within this section, we provide a summary of the advantages and challenges in adding new non-medical providers.

Because individuals participating in CFC should be the drivers of this decision process, we first present a summary of the participant perspective. All three types of participants expressed support for adding more providers, especially within the homemaker participant group. While about half of all participants (between 46% and 57%) responded that adding new providers would be either very helpful or helpful, less than a third (between 21% and 31%) thought new providers would be not at all helpful or not helpful. Once again, homemaker participants were the most supportive with 57% thinking new providers would be very helpful or helpful and only 21% thinking that new providers would not be helpful. Non-medical providers may help the homemaker group the most in terms of access and choice. Overall, participants support the addition of non-medical providers, which should be a major consideration for Vermont policymakers.

More globally, the following table brings together the benefits and challenges of adding non-medical providers, as synthesized from literature reviews, interviews with key informants, consumer survey responses and state reviews.

Domain	Benefits	Challenges
Access	○ Increases the number of providers ○ Expands the options for participants ○ May allow for the inclusion of providers who are willing to do things differently (e.g. transportation) ○ Offers more staffing opportunities for times of day that are more difficult to cover (evening, overnight and weekend) ○ Expands access to non-medical providers (access that is currently limited to people using Flexible Choices)	○ May complicate the system, making it difficult for participants and families to choose and access services ○ May decrease access to services if Home Health Agencies leave the market
Choice	○ Gives the participant more options ○ Allows the participant to decide which agencies can meet needs the best ○ Empowers the participant who selects a provider to manage services without feeling dependent on one organization ○ May encourage provider agencies to 'compete' for participants by providing high quality and responsive services ○ Permits participants in all locations to have options of service providers ○ Permits participants who choose Consumer-directed/Surrogate-directed services to have another alternative to agency services	○ May create confusion for participants through the addition of more organizations ○ May diminish choice if Home Health Agencies leave the market

Cost/ Financial Impact	○ Decreases some service cost (costs per unit switched from HHA higher cost providers to non-medical providers) ○ Reduces some system costs if more people can be supported at home ○ May create incentives for providers to improve wages, benefits and working conditions for direct service workers ○ Creates opportunities for Home Health Agencies to expand service reach by adding a non-medical provider entity to their agencies' menu of service options ○ Would not involve some "start-up" costs for non-medical providers currently operating in Vermont	○ Increases some service unit costs (costs per unit switched from Consumer-directed/Surrogate-directed services to non-medical providers) ○ May create market that is not profitable enough for certain current Home Health Agencies to provide CFC services ○ Compels the State to manage provider taxes and reimbursement rates to ensure no unintended shift in revenues versus costs ○ Increases some costs to providers due to additional reporting to the State ○ Increases some costs to State in administration and oversight of CFC, e.g. additional reporting from providers ○ Increases some costs and resource needs for providers if required training or certification of PCAs is implemented
Quality and Outcomes	○ May offer an incentive for improved training for direct service workers, increasing workforce quality ○ Increases access, one outcome of a high quality system, because participants may be better able to receive all of the services they need ○ Increases opportunities to allow a person to remain at home, a "choice" outcome ○ Competition for participants may help to ensure quality of services	○ Would require the State to develop and implement procedures, standards and quality monitoring for a new set of providers.

In conclusion, the findings suggest that the addition of non-medical providers would improve access, choice and quality. The findings further suggest that adding providers would have either a neutral or positive impact on cost by decreasing service costs but adding some new State administrative and oversight costs. The findings also suggest some changes to the processes and the structure of the CFC service delivery system should be addressed if non-medical providers are added.

The inclusion of non-medical providers would fundamentally expand participants' options of PCA and homemaker services. Building on the current system which allows Consumer-directed/Surrogate-directed and Flexible Choices participants to use non-medical providers to obtain PCA services, DAIL can ensure that participants who select to receive their services through an agency are also aware of this option. The inclusion of non-medical providers takes all participants out of an environment which one could say is currently exemplified by Henry Ford who said, "People can have whatever color car they want as long as it is black." For many Vermonters, this has meant that if they choose to work with an agency, they have one Home Health Agency to choose.

In terms of cost, it should be acknowledged that as the population ages and as more people with disabilities pursue independent lives in the community, individuals' use of CFC will increase. In 2006, Vermont projected that over the next ten years, there would be a 36% increase in the number of people with disabilities in Vermont, potentially requiring CFC services (Wasserman, 2006). This increased demand can be expected to increase the cost of the CFC program. It is possible that the inclusion of non-medical providers, which are a lower cost provider as compared to agency providers, may ultimately only slow down the future overall increase cost of long-term support services. To the degree that Vermont can support more people in their own homes and communities while controlling the costs of their services, Vermont will further the vision of Choices for Care.

Given the summary of the benefits and challenges of the addition of non-medical providers, it is reasonable and appropriate for Vermont to add non-medical providers. The section below provides some specific recommendations to assist Vermont in determining how best to proceed with this addition.

Vermont has a history of developing systems which promote and support the provision of quality services. The inclusion of non-medical providers would require that DAIL quality assessment and management systems be extended to incorporate this new provider type. Because the non-medical providers are not Medicare certified, Vermont has the opportunity to establish criteria which best maximizes its vision of a quality system for the CFC program. Adding oversight of these non-medical providers will benefit not only CFC participants, but also private pay participants.

Over the years, other states have reorganized their long-term support service delivery system. Maine, Massachusetts, Montana and New Hampshire have developed systems which allow a mix of non-profit and for-profit organizations to qualify to provide Home and Community-Based Services, including non-medical providers. In New Hampshire, "68% of agencies have been in existence for twenty or more years: more than half are private non-profits, a quarter are private for-profit agencies and the remainder are publicly owned or part of a hospital or health system" (Smith, 2009). In the 1990s when Maine transitioned its home health system to one which includes a wider mix of service providers, there were disruptions and predictions of dire circumstances. Today, Maine contracts with one organization for nurses to conduct consumer needs assessments across the state. There are AAAs in different regions with one AAA responsible for managing the providers. Independent Living Center serves as the fiscal intermediary. Today, Maine ranked as one of the high performing states according to the recently released Long-term Support Services Scorecard report from AARP, the Scan Foundation and the Commonwealth Fund (Reinhard, Kassner, Houser, and Mollica, 2011).

Policy Recommendations

Based on the findings, we, CFC's external evaluators, recommend that Vermont open its CFC HCBS service delivery system to additional non-medical providers. If the expansion is carefully and deliberately implemented, access and choice will be expanded and enhanced, costs will be controlled and quality will be maintained or improved.

Specifically, we recommend that Vermont adopt a phased-in approach to the expansion to non-medical providers with the following components:

- Open the CFC market to non-medical providers, thereby removing the incomplete geographic monopoly of Home Health Agencies as a mechanism for providing HCBS services to CFC participants. Over time, allow

transition of Personal Care Attendant (PCA) and homemaker services to non-medical providers, based on individual choice. As part of this expansion, current HHAs could elect to create separate non-medical provider entities of their own. Under this model, a Home Health Agency may spin off its CFC services to a separate non-medical provider. Additionally, as some interviewees observed, nursing facilities and other entities in the continuum of care may want to create non-medical provider entities which would allow them to continue serving participants who move back into the community.

- Develop certification criteria and/or processes for any non-medical organization which would like to provide Home and Community-Based Services to CFC participants. This process could specify a number, small at first, of non-medical providers to be added during a given time period to ensure a deliberate and incremental approach, allowing for fine-tuning as additional non-medical providers become certified. As part of the certification, develop criteria and a process by which non-medical providers enroll CFC participants.
- Maintain current case management services with the Home Health Agencies and Area Agencies on Aging. As part of this maintenance, DAIL could monitor, at least initially, the referral rates of HHAs to non-medical providers.

Since the expansion of CFC providers will result in systemic changes, Vermont should use a 2-year statewide phase-in process. This phase-in process can be implemented with the following structural changes:

1. Open the CFC market non-medical providers (including HHA-organized non-medical entities) by eliminating the incomplete geographic monopoly of Home Health Agencies and allowing non-medical providers to qualify to provide PCA, homemaker, Respite and Companion services. Vermont should pay close attention to homemaker services as participants with these services seem prime "beneficiaries" of the expansion.
2. Revise CFC regulations to include non-medical providers, ensuring a thorough regular certification process to qualify and monitor non-medical providers.
3. Develop and/or revise materials to help participants understand and choose among the variety of settings and types of providers, based on the current "How to Choose a Case Manager" brochure and "Choices for Care Long-Term Care Options" brochure. For example, DAIL can contribute to informed choice by crafting a list of easily understood questions to aid participants in selecting service settings, service models, and service providers.
4. Work with participants, surrogates, providers, direct service workers and State officials to develop a set of recommended minimum skills and knowledge competencies for PCA workers (Paraprofessional Healthcare Institute, 2004). While required training for direct service workers is controversial to some stakeholders, Vermont may consider implementing a basic training course, similar to New Hampshire's. DAIL, participants and other stakeholders could determine the core minimum skills needed by anyone providing Personal Care including respite and companion services. Drawing on training curriculum from other states and the detailed best practices curriculum of the Longevity Center (2008), DAIL could include communication and interpersonal skills, techniques for aiding with hygiene, reporting elder abuse and fraud and resources in the community for elders and people with disabilities, while ensuring that the curriculum meets the goals and objectives of the CFC program. This model does not preclude participants from then doing their own individualized training. Not only will this ensure a minimum training level, but another outcome may be greater respect and value for PCA/homemaker staff.
5. Assess the impact of the expansion on the following:
    - Participants through use of the current annual consumer satisfaction survey measuring access, choice and quality with a specific module of questions for participants who use non-medical providers.

- Participants and providers through ongoing quality reviews and provider monitoring including complaints
- Providers of personal care, respite care, companion care, and homemaker services through annual reports of financial status including revenues, expenses, fund balance and worker status including full/part-time workers, rate of turnover, wages and trainings
- CFC outcomes and performance through evaluation measures related to enrollment, costs, service quality, and service utilization.

By adopting these actions, DAIL can implement the expansion of its provider network to include non-medical providers. Additionally, these recommended processes will allow the on-going evaluation of any changes.

Conclusion

We recommend that Vermont add non-medical providers to the Choices for Care HCBS system, with benefits related to the following domains:

- Access: There are participants who currently do not receive the services they need. Some people live in rural areas where it is difficult to find workers. Some people live in more urban areas and would like to receive services at times that are difficult for providers. Non-medical providers can help to meet these gaps. This may have the most impact on access for participants with homemaker services.
- Choice: Additional and varied providers will allow participants to have more options for services including participants who, at this point, have not experienced as much of a choice because of the incomplete geographic monopoly of the HHAs. Participants will have improved choice of agencies, and will not be compelled to use Consumer-directed/Surrogate-directed options as their only viable alternative. Again, non-medical providers may impact choice for homemaker participants most directly and immediately.
- Cost: A decrease in costs is anticipated because non-medical providers should be reimbursed at a lower rate than HHAs. This decrease may be mitigated by two trends: 1) the replacement of Consumer-directed/Surrogate-directed services (which are at a lower rate) with non-medical providers and 2) the ongoing population demographics, creating a higher demand for services. Due to increased competition, the State may find that the increase of expenditures is slower because non-medical providers are a less costly alternative. Also, serving more people at home may further counterbalance any possible increases in HCBS costs.
- Quality: Because access and choice are two components of quality and non-medical providers are beneficial in those two domains, quality is expected to remain the same or improve if appropriate quality monitoring, as recommended above, are implemented.

The inclusion of non-medical providers must be taken with due consideration of the impact on the current system and providers. Choices for Care and its recipients do not exist in a health care vacuum. There are initiatives looking at the creation of a PCA Cooperative, the on-going implementation of the Blueprint, Care Transitions, the Dual Eligible initiative, Money Follows the Person and Vermont's progress towards a single payer system as well as consideration of developing CFC HCBS case rates. With many of these initiatives impacting the lives of elders and people with disabilities, DAIL can ensure that the intersections between CFC and these other programs are consistent with CFC's principles of choice, access and quality, improving care and improving outcomes while controlling costs.

As Vermont considers next steps, we recommend a two-year statewide phase-in of the addition of non-medical providers. During this period, Vermont can examine the effect of expanding the CFC market to non-medical providers and ensure improvements in access, choice and quality for participants. If Vermont implements these steps in a phased approach, it can fine-tune the details of a system which best achieves the goals of CFC. All of the research suggests that this type of service delivery system, which allows for a mix of settings, options and providers including non-medical providers, will benefit participants, their families, providers, taxpayers and the State.

Resources

UMass Medical School's Disability and Community Services conducted interviews with over sixty key informants during preparation of this policy brief. These key informants included the following:

- Home Health Agency
- Hospital discharge planners
- Area Agency on Aging
- Adult Day program
- DAIL staff including DAIL business office
- Vermont Center for Independent Living
- Non-medical providers/directors/owners
- Direct care workers
- Nursing Homes/ Residential Care/Assisted Living staff
- Department of Licensing and Protection staff
- Vermont Assembly of Home Health Agencies
- Vermont Association of Area Agencies on Aging
- Vermont Health Care Association
- Vermont Assembly of Home Health Agencies
- Vermont Association of Hospitals and Health Systems
- PACE Vermont
- Home Health Agencies, Accountant
- Department of Vermont Health Access Program Integrity Unit
- Support and Services at Home (aka 'SASH')
- Homeshare Vermont, Home Share Now.

References

Cumings, C. & Bruner-Canhoto, L. (2011). Vermont Choices for Care: Evaluation of Years 1-5, Draft Report. Shrewsbury MA: Commonwealth Medicine, University of Massachusetts Medical School. Retrieved from http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/vt-cfc-evaluation-years-1-5

DeBrantes, F. & Camillus, J.A. (2007). Evidence-informed case rates: a new health care payment model. Retrieved from http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Apr/Evidence-Informed-Case-Rates--A-New-Health-Care-Payment-Model.aspx

Doty, P., Kasper,J. & Litvak, J. (1996). Consumer directed models of personal care: lessons from Medicaid. Milbank Quarterly, 74(3), 377-409.

HR Hero. (2011, December 15). New Rules Proposed to Provide FLSA Protections to In-Home Care Workers. Message posted on http://blogs.hrhero.com/hrnews/2011/12/15/new-rules-proposed-to-provide-flsa-protections-to-in-home-care-workers/

Kaye, H.S., Harrington, C. & LaPlante, M.P. (2010). Long-term Care: Who gets it, Who provides it, Who pays, and How much? Health Affairs, 29(1), 11-21.

Keilson, J. (2004). Recruiting human service workers in good times and otherwise. Baltimore, M.D.: U.S. Centers from Medicare & Medicaid Services (CMS). Retrieved from http://www.directcareclearinghouse.org/s_state_det5.jsp?res_id=21&action=null

Keilson, J. (2004). Massachusetts Recruiting Direct Service Professionals/Personal Assistance in a Competitive Environment. Promising Practices in Home and Community- Based Services. Baltimore, M.D.: U.S. Centers from Medicare & Medicaid Services (CMS). Retrieved from http://www.directcareclearinghouse.org/s_state_det5.jsp?res_id=21&action=null

Lewin Group. (2007). Approaches to Worker Training in Participant-Directed Services. DSW Resource Center Webinar: Consumer-Directed Care Training Programs Part II.

Newcomer, R.J., Kang, T. & Doty, P. (2011). Allowing Spouses to be Paid Personal Care Providers: Spouse Availability and effects on Medicaid-funded Service Use and Expenditures. The Gerontologist, Published on-line October 19, 2011. Retrieved from http://gerontologist.oxfordjournals.org/content/early/2011/10/18/geront.gnr102.abstract

O'Connor, D. (2009). Vermont Choices for Care Policy Brief: Quality Oversight. Policy Brief. Shrewsbury, MA: Commonwealth Medicine, University of Massachusetts Medical School.

Personal Care Attendant Workforce Council (2008). PCA Workforce Council Brochure. Boston, MA: Executive Office of Health and Human Services. Retrieved from http://www.mass.gov/pca/about/brochure.htm

Pohlman, L. (2003). Without Care: Maine's Direct Care Worker Shortage. Augusta, Maine: Maine Center for Economic Policy. Retrieved from http://www.directcareclearinghouse.org/download/Rep03_direct_care_workers.pdf

Private Duty Today. (2011). Guides to Home Care Licensing in Your State. Retrieved from http://www.privatedutytoday.com/guides/licensing/index.htm

Reinhard, S.C., Kassner, E., Houser, A. & Mollica R. (2011). Raising expectations: a state scorecard on long-term services and supports for older adults, people with physical disabilities and family care givers. Retrieved from http://assets.aarp.org/rgcenter/ppi/ltc/ltss_scorecard.pdf.

Robertson, B., Maurice, J. & Madden, P. (2011). Vermont Long-Term Care Consumer Survey. Portland, ME: Market Decisions.

RPC Consulting. (2011). Analysis of Opportunities for Certificates of Need For Home Health Agencies in Selected States. Austin, TX. Retrieved from http://www.rpcconsulting.com/certificates-of-need-CON-for-home-health-agencies.htm

The Vermont State Data Center. (2007). Burlington, VT: The Center for Rural Studies. Retrieved from http://crs.uvm.edu/census/projections/state/

Weiner, J. & Anderson W. (2009). Follow the Money: Financing home and community based services. Pittsburgh, PA: Pennsylvania Medicaid Policy Center, University of Pittsburgh. Retrieved from http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf

Policy

Alecxih, L. (2008). Can Home and Community Based Services be expanded without Bursting the Budget? [Presentation (PPT)] The Lewin Group, Presented at the National Academy for State Health Policy.

Borbridge, B. (2011). Choices for Care Provider Addition Study. Report provided to the Interviewers, October 2011.

Bubar, K., Ring, C., Yoe, J., Turyn, R.& Muesky Project Staff (2009). A Cross-System Profile of Maine's Long Term Support System: A New View of Maine's Long Term Services and Supports and the People Served. Report Prepared for CMS, State Profile Tool Project.

Frydman, D. & Winchester, M. (2005). New Hampshire Consumer-Directed Care: A Gap Analysis. Concord, NH: Institute for Health Law and Ethics, Franklin Pierce Law Center.

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

Institute of Medicine (2008). Retooling for an Aging America: Building the Healthcare Workforce. Policy Brief. April 2008. Retrieved from http://hcbs.org/moreInfo.php/nb/doc/2232/Retooling_for_an_Aging_America:_Building_the_Healt

Levison, Daniel R. (2006). State's Requirement for Medicaid-funded Personal Care Service Attendants. Washington, D.C.: Office of the Inspector General.

Paraprofessional Healthcare Institute. (2004). The Right Start: Workforce Tools, #2. Centers for Medicare & Medicaid Services Research Project on the Availability of Personal Assistance Services.

Polhlmann, L. (2006). Meeting Maine's need for frontline workers in long term care and service options. Prepared for Blaine House Conference on Aging. Portland, ME: Maine Center for Economic Policy. Retrieved November 27, 2011

Smith, K. (2009). Home care workers: Keeping Granite Staters in their homes as they age. Policy Brief #2. Durham, NH: Carsey Institute, University of New Hampshire. Retrieved from http://www.carseyinstitute.unh.edu/CarseySearch/search.php?id=77

Wasserman, J. (2006). Shaping the Future of Long-Term Care and Independent Living. Waterbury, VT: Vermont Department of Disabilities, Aging and Independent Living.

AARP. (2010). 2010 Survey of AARP Vermont Members Age 50+ on Health and Livable Community Issues. Washington, DC: AARP.

The Caregiving Project for Older Americans. (2009). Caregiver Training in America and Southern California: Results of a National Review. New York, NY: International Longevity Center (ILC) Retrieved from http://www.hcbs.org/moreInfo.php/doc/2521

Data on Charges for Non-medical Providers. Email communication, received December 15, 2011.

Finding a Quality Home Care Agency. Denver, CO: Colorado Department of Public Health and Environment. Retrieved from http://www.cdphe.state.co.us/hf/download/FindingHomeCareAgency.pdf

Genworth Financial. (2008). Genworth Financial 2008 Cost of Care Study: Home care providers, adult day health care facilities, assisted living facilities and nursing homes. Richmond, VA: Author.

Joint Fiscal Office Vermont. (2011). Basic needs budgets and the livable wage prepared in accordance with 2v.S.A. Section 505. Vermont.

JSI Research Training Institute (2009). Consumers' Experience in the Massachusetts Personal Care Attendant Program. Report prepared for the Personal Care Council, May 2009.

The Metlife Mature Market Institute. (2011). The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. Westport, CT: MetLife Mature Market Institute. Retrieved from http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf

Montana Senior and Long-term Care Division. (2011). Presentation to the 2011 Health and Human Services Joint Appropriations Sub-committee, Legislative Fiscal Division Budget Analysis, 4: B, B254- B291.

National Association for Home Care and Hospice (2008). Basic Statistics about Home Care, Updated 2008. Washington D.C.

National Private Duty Association. (2011). Private Duty Home Care Industry Fact Sheet. Retrieved from http://www.privatedutyhomecare.org/downloads/NPDA-FactSheet.pdf

Northeast Kingdom Homecare Inc. Determining Positive Outcomes from Adult Day Services. Newport, VT. Retrieved from interview source November 4, 2011.

Paraprofessional Healthcare Institute (2006). Reimbursement practices and issues in Vermont's long-term care programs. Prepared for the Long-Term Care Workforce Policy Committee of the Community of Vermont Elders(COVE). Retrieved from

http://www.directcareclearinghouse.org/download/VT%20Reimbursement%20White%20Paper%20Final%20Nov%2006.pdf

Paraprofessional Healthcare Institute. (2009). Vermont's Direct-Care Workforce. State Facts. New York, NY: PHI. Retrieved from http://www.directcareclearinghouse.org/download/PHI-StateFacts-VT.pdf

Paraprofessional Healthcare Institute (2011). The State Chart Book on Personal Care Aids Wages 2000 – 2010. August 2011.

Retrieved from http://www.directcareclearinghouse.org/download/PCAwages-2000to2010.pdf

Services for elders and other adults who need long-term home-based community-based care. (2010) A report to the 124th Maine Legislature by the Maine Department of Health and Human Services about 4 related pieces of legislation: LDS 400, 1059, 1078, and 1364. Retrieved from http://www.maine.gov/dhhs/reports/ltc-services-adults.shtml.

Standards for non-medical home care agencies in Vermont. Draft document shared with the Interview team on November 4, 2011.

States In-Action Newsletter. (September/October 2010). The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Oct/September-Oct-2010.aspx

Task Force on Direct Care Workers (2010). Report on the Direct Care Workforce in Maine submitted to the Maine Department of Health and Human Services. Retrieved from http://www.maine.gov/dhhs/reports/ltc-services-adults.shtml.

Rewarding Work Resources. (2010). Vermont Direct Care Registry Survey Highlights. Brookline, MA. Retrieved from http://www.rewardingwork.org/en/State-Resources/Vermont/Newsroom.aspx.

Regulations and Statutes

Chapter 119: Regulations Governing the Licensing and Functioning of Home Health Care Services. Bureau of Medical Services. Maine Department of Health and Human Services. July 2005.

DAIL/DDAS Services: Medicaid Claims Codes and Reimbursement Rates version 8.1.11. Retrieved from http://www.ddas.vermont.gov/ddas-publications/publications-ddas/publications-ddas-default-page

Vermont, Choices for Care 1115 Long-term Care Medicaid Waiver Regulations. Effective 2009. Retrieved from http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#legislation

Vermont, Title 33: Human Services Chapter 63: HOME CARE PROGRAMS 33 V.S.A. § 6304. Designation; geographic service areas.

Vermont, Act 63, (2011) An Act related to Making Appropriations for the Support of Government. Sec. E. 300 (c): 135-136. Retrieved http://www.leg.state.vt.us/docs/2012/ACTS/ACT063.pdf.

Contact Information

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

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

UMASS MEDICAL SCHOOL
Commonwealth Medicine
Applied Knowledge in Public Service