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Consumer-Directed Options

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CONSUMER-DIRECTED OPTIONS

For more than 35 years, the National Aging Services Network has played a key role in creating more options for seniors and others with disabilities to remain in the community. One of these options is consumer-directed services where clients can exercise a greater degree of control and choice over the services that they receive and how they are delivered as compared to the traditional agency model. The range of services that can be offered in this way is quite broad and can include but is not limited to nutrition, transportation, caregiver support, and personal care services. Consumer directed options are most often provided for personal care services. Under these options, the client can hire personal care attendants and caregivers, set the work hours specific to their own needs (versus those of an agency's schedule), and identify, hire, and supervise the attendant they choose. Caregivers do not need to be agency employees. Instead they may be neighbors, friends, and, in some cases, family and spouses of the individuals needing care, although the rules about who may be employed vary in each state. Many programs also train the consumer in employee management and offer fiscal intermediary services so the consumer does not have to establish individual tax or employment benefit mechanisms.

Consumer-directed service options may be very cost-effective options for a state because they no longer pay the administrative and management costs of an agency; these costs are absorbed by the client. And while the overall costs may be lower to the state, in many areas (although not all), consumer directed attendant salary levels are often higher than those paid to an agency attendant. However, consumer-directed options may also increase the client's exposure to potential fraud and abuse. Direct supervision is provided by the client who is generally responsible for ensuring that his/her attendant provides good quality care.

Clients like this service model because it increases their personal choice, control, and flexibility in accessing personal care services. It also increases their options for hiring assistants despite shortages in the paraprofessional workforce. This option also improves the opportunity to provide culturally appropriate services for ethnic minorities by utilizing extended family networks.

Consumer directed options grew out of the Independent Living movement as younger adults with disabilities in the 1970s demanded greater control of their services. In response, many states established consumer-directed programs for people of all ages (Wiener et al., 2002,

Coleman, 2001, Squillace et. al, 2001). Today, almost every state (except Tennessee and the District of Columbia) has some type of a consumer-directed community-based option (Coleman, 2003) although many programs are small and may target younger populations. The majority of these programs (65 percent) were established after 1990, but 11 percent have been in place over 20 years (Ibid.). States such as Colorado, California, Michigan, Oregon, Vermont and Washington have mature consumer-directed programs. Among the newer programs are those in New Jersey, Arkansas and Florida, which are part of the Cash and Counseling demonstration jointly funded by the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation and the Robert Wood Johnson Foundation (RWJF) (Coleman, 2003). Many states are using their Medicaid waivers to establish programs and similar efforts are underway across Europe (Wiener, Tilly and Cuellar, 2003).

State consumer-directed programs vary in the number and range of tasks for which consumers assume responsibility. *Direct Pay* systems allow consumers to perform all functions, including payroll and tax responsibilities. A *Fiscal Intermediary* model includes a state agency or private agency hired by the state to assist consumers with taxes, payroll and other paperwork. *Supportive Intermediary* models expand the role of agencies into assistance with hiring, recruiting, criminal background checks, and training (Coleman, 2001). Programs range from those where beneficiaries rely on guidance and help from case managers to choose, hire, and fire aides and monitor services, to programs modeled after voucher systems where recipients receive monthly cash benefits and have sole responsibility for hiring, firing, managing and directing workers, and for making home modifications (Benjamin, 2001; Doty et al, 1999; Foster et al, 2000).

States are expanding consumer-directed (CD) programs to meet the growing demand from elders and younger adults with disabilities. However, opponents express concerns about the quality of care and the capacity of older people to carry out the management functions (Tilly and Wiener, 2001). Information about the impact of one consumer-directed option is available from the evaluation of the Cash and Counseling Program, a three-state demonstration project in which Medicaid beneficiaries received a monthly cash allowance for personal assistance services, along with counseling services to assist them in using the allowance effectively (Doty, 1998, Foster, 2000, Coleman, 2001, Mahoney et. al, 2003). In Arkansas, the Cash and Counseling Program was better able to meet recipients' needs. Personal care costs were higher

for people receiving cash and counseling than for people receiving agency-directed services because of improved access to services (agencies often were unable to provide care due to staff shortages), but these higher costs were offset by lower nursing home costs (Dale, Brown et. al, 2003). The consumer-directed clients also used more medical equipment in general, and there were fewer disparities between White Americans' and African Americans' use of this equipment in these programs. Consumer-directed home care also allowed consumers greater flexibility in purchasing equipment, goods and services; in other words, expanded choice in care options beyond direct personal assistance (Foster, Brown, et al, 2003; Meiners & Loughlin, 2003).

The findings from the Cash and Counseling demonstration also highlight the enormous value consumers place on being able to hire friends, family members or persons of their own choosing. In the demonstration program, the majority of consumers hired friends and family, who were paid for about 12 hours of care a week, on average, and still continued to provide substantial amounts of unpaid care (San Antonio, Eckert et al., 2003).

This report is part of a series of case studies focusing on programs where the Aging Network has played a leading role in developing services and options for older adults. In consumer-directed care, few state aging networks have been more involved than Vermont. For the past 20 years, Vermont has undertaken considerable effort developing its consumer-directed approach to health and long-term care, including significant supports to consumers and their families who choose to participate in consumer-directed programs.

VERMONT'S CONSUMER-DIRECTED PROGRAMS

Vermont has one of the nation's oldest and most well-established consumer-directed programs. It began in 1980 as a state-funded attendant services program and has continued to expand over time, adding a consumer-directed Medicaid home and community-based waiver component in 1997, a surrogate-directed Medicaid waiver component in 1999 and a Medicaid state plan component in 2002. Additional federal grants and private foundation funding have also been used to help develop this system. This report describes these programs, their funding sources, and client pathways to services. The first section provides an overview of Vermont's demographics, long-term care financing, and recent policy changes as a context in which these programs operate. The second section discusses the consumer-directed programs and the third part identifies key factors contributing to the programs' growth and success over time.

I-1 OVERVIEW OF LONG-TERM CARE IN VERMONT

A. Demographics

Vermont is a small, rural New England state. In 2002, there were 77,510 residents aged 65 or older (Nawrocki and Gregory, 2000); 58.7 percent living in rural parts of the state. Of the older adult population, 3,429 people resided in nursing homes. Most of the residents are Caucasian, with small numbers of ethnic or minority individuals residing in the state.

Being a rural state creates its own challenges for delivering community-based services. Besides the barriers formed by geographic dispersion, rural populations often have a limited choice of providers. In Vermont, consumers frequently have only one provider in an area from which to select.

B. Long-Term Care Financing

Long-term care in Vermont is largely financed by the Medicaid program which accounted for 93 percent of the state's long-term care expenditures for the older adult and disabled populations in FY 2002 (Vermont, 2004; AARP, 2004). Of the \$116 million financed by Medicaid, 78 percent paid for nursing facility services (Table 1). Medicaid waivers for older adults and younger persons with disabilities account for 53 percent of all community-based expenditures. Other Medicaid waivers for community services, such as those for Traumatic Brain Injury (TBI) and Enhanced Residential Care (ERC), account for another 11 percent of the

based spending. The state-funded component of the attendant services program is the next largest program (\$3.4 million) accounting for 10 percent of all community-based expenditures in 2002. This is followed by the Adult Day Services Program which accounted for another 6 percent of home and community-based spending.

Table 1
Vermont LTC Expenditures, 2002

	FY2002 <u>Expenditures</u>	As % of <u>Total LTC \$</u>	As % of <u>Total HCBS \$</u>
Nursing facility	\$90,552,604	71.5%	---
Waivers			
Aging and Disabled Home-Based	19,317,506	15.2	53.4%
TBI and ERC	3,830,206	3.0	10.6
ASP			
Medicaid	181,364	0.1	0.5
State	3,448,283	2.7	9.5
Adult Day			
Medicaid	841,442	0.7	2.3
State	1,277,697	1.0	3.5
Homemaker	801,427	0.6	2.2
HASS	530,027	0.4	1.5
Dementia Respite	222,902	0.2	0.6
MH & Aging Initiative	250,000	0.2	0.7
Older Americans Act	5,441,051	4.3%	15.1%
Total LTC *	\$126,694,509	100.0%	---
Total HCBS	\$36,141,905	28.5%	100.0%
Total State	\$6,530,336	5.2%	18.1%
Total Medicaid HCBS*	\$24,170,518	19.1%	66.9%
Total OAA	\$5,441,051	15.0%	15.0%

NOTES:

*Totals rounded to nearest tenth.

*Does not include Developmental Services Waiver or Children's Mental Health Waiver

HCBS: Home and Community-based Care

TBI: Traumatic Brain Injury

ERC: Enhanced Residential Care

ASP: Attendant Services Program

HASS: Housing and Supportive Services

MH: Mental Health

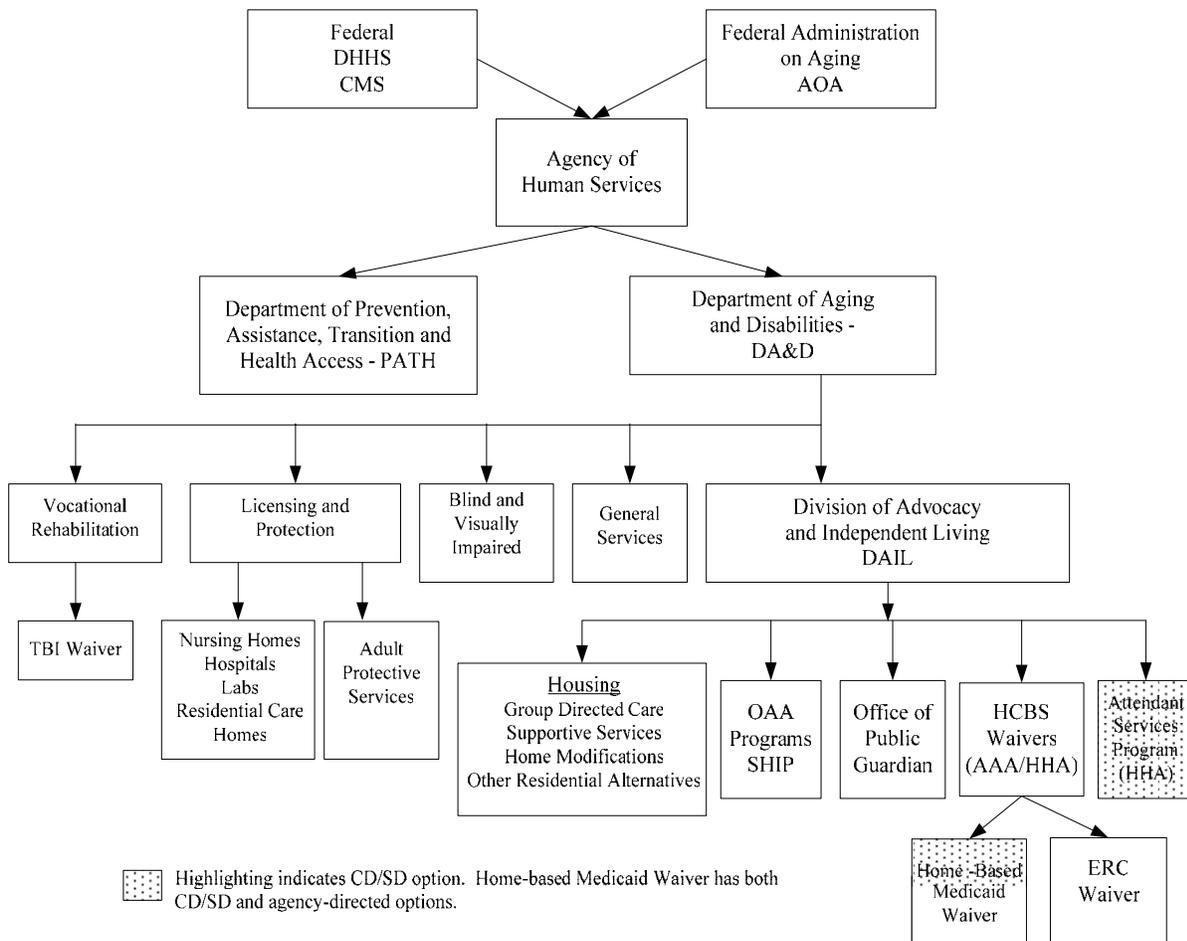
LTC: Long-Term Care

SOURCE: Vermont Department of Aging and Disability Services, 2004.

C. Vermont's LTC System and Policy Changes

Aging services in Vermont are administered by the VT Agency of Human Services (AHS) which houses both the Medicaid Division (the Office of Vermont Health Access), the Department of Prevention, Assistance, Transition, and Health Access (PATH) and the Department of Aging and Disabilities (DA&D), which is the State Unit on Aging, (see **Figure 1**). PATH determines financial eligibility for all Medicaid covered services including those administered by DA&D.¹ DA&D administers all Medicaid and state-funded long-term care services including institutional and community-based services for elders and adults with physical disabilities. (Consumers with mental health and developmental disabilities are served by another department within AHS).

**Figure 1
Long-Term Care System in Vermont**



¹ Clinical eligibility for these services is determined by the Division of Licensing and Protection, another division within DA&D.

Within DA&D is the Division of Advocacy and Independent Living (DAIL) which manages Vermont's Independent Living Services: a set of 12 community-based programs that includes six personal care options for the older adult populations –

- the Consumer-Directed Attendant Service Program (ASP) which has 3 components - two are funded by state general funds and one is funded by Medicaid – the eligibility criteria vary by component;
- the Medicaid home and community-based services waiver which has three personal care options (agency-directed, consumer-directed, and surrogate-directed). (Vermont also has an Enhanced Residential Care Waiver, which does not have a consumer-directed option).

The state also offers community-based services through 28 Housing and Supportive Services (HASS) sites which use state dollars to bring supportive services to elders and younger adults with disabilities living in congregate housing settings. These programs are managed by regional LTC community coalitions which are comprised of consumers, providers, and advocates, and are charged with improving long-term care service coordination in their areas. The coalitions receive \$100,000 per year in flexible state funding which they can use to authorize gap-filling services. The 28 HASS sites served approximately 1100 residents in 2001 (DA&D Annual Report, 2002).

The state has several initiatives underway which complement these programs by increasing the potential availability of appropriately trained personal care attendants. Vermont's Real Choice Systems Change Grant is being used to:

- identify the gaps in consumer information and services,
- identify best practices for fostering self-determination, self-advocacy, and recovery among consumers,
- create a well trained and adequately reimbursed workforce,
- develop a Medicaid 1115 federal demonstration waiver to increase community-based services and eliminate the long-term care institutional bias, and
- develop and implement a pilot project for direct funding for supports and services to people with disabilities and their families.

In addition, the Robert Wood Johnson Foundation and the Atlantic Philanthropies are providing complementary funds for the Real Choice Systems Change project to a consumer advocacy organization, the Community of Vermont Elders (COVE) to work with the state DA&D, Vermont Health Care Association, the Vermont Association of Adult Day Programs and the Vermont Assembly of Home Health Agencies. Through the state's Better Jobs-Better Care

grant, they are developing provider training materials, resources and certification standards for direct care workers. This team also will be addressing sustainable reimbursement structures for direct care workers and educating policymakers about the value of professional development for these staff.

Most recently, Vermont applied for a new Medicaid 1115 research and demonstration waiver which will entitle clients to home and community-based services waiver services as readily as their entitlement to institutional care. The additional goal of the demonstration is to serve more individuals in the community. Many of these efforts derive from legislative activity in the mid-1990s. In 1996, the Vermont legislature passed Act 160, which directed the state to begin to shift the balance from nursing home services toward the development of more home and community-based services. First, it directed the Department of Aging and Disabilities (DA&D) to eliminate 6 percent of all nursing home beds (234 beds) by 2002 and shift the savings into expanded home and community-based services. Since then, Vermont has seen a marked shift in its long-term care system towards relatively greater use of home and community-based care. Nursing facility occupancy is down to 90 percent compared to a historic peak of 98 percent (Stern, 2002).

II. INNOVATION OVERVIEW: CONSUMER-DIRECTED AND SURROGATE-DIRECTED PERSONAL CARE OPTIONS

Consumer choice is a central tenet of Vermont's home and community-based system. In these programs, if participants are willing to be the employer and able to direct their own care, or if they have a surrogate who can be the employer, they recruit, train, and supervise their own attendants. Payroll services are provided by a fiscal intermediary under contract with the state.

A. Options Comparison

As mentioned above, consumer-directed options in Vermont are available through two sets of programs: the Attendant Services Program (ASP) and the Medicaid home and community-based services waiver program. The ASP was established in 1980 with state funds to provide personal care services to people with one or more limitations in activities of daily living (ADL). It was originally established because of strong advocacy efforts by the Independent Living movement seeking ways to help disabled beneficiaries returning to work.

Today, there are three components to the ASP (*Figure 2*). Participants who are Medicaid eligible can qualify for the state-funded ASP program if they have one or more ADL limitations.

income clients may also be eligible for the state-funded services if they have difficulties with two or more ADL limitations. They also may hire spouses as attendants.

Figure 2
Vermont's Personal Care Programs for Elders and Adults with Physical Disabilities

<u>Program</u>	<u>ASP</u>	<u>ASP</u>	<u>ASP</u>	<u>HBW</u>	<u>HBW</u>	<u>HBW</u>
Directed by:	Consumer	Consumer or agent	Consumer	HHA	Consumer	Surrogate
Funding Source:	State GF	State GF	Medicaid State plan	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver
Eligibility:						
Functional	Severe disability 2+ ADLs	Severe disability 1 ADL	Severe disability 2+ ADLs	NF Level of Need	NF Level of Need	NF Level of Need
Income	none	Medicaid	Medicaid	NH Medicaid	NH Medicaid	NH Medicaid
Services	Personal care	Personal care	Personal care	Personal care, respite ,CM, adult day, PERS assistive devices home mods companion	Personal care, respite, CM, adult day, PERS assistive devices home mods companion	Personal care, respite, CM, adult day, PERS assistive devices home mods companion
Service cap	13 hours/day	13 hours/day	13 hours/day	Based on need	Based on need	Based on need
Caregivers	spouse, others	spouse, others	others	others	others	others
Assessors	HHAs	HHAs	HHAs	HHA or AAA	HHA or AAA	HHA or AAA
Authorization	ASP eligibility committee	ASP eligibility committee	ASP eligibility committee	PATH & DA&D Licensing & Protection	PATH & DA&D Licensing & Protection	PATH & DA&D Licensing & Protection
<u>FY 2003*</u>	<u>ASP</u>			<u>HCBW</u>		
Funding levels	\$4,122,537			\$23,260,998		
Enrollment	375			1,430		
Age Range	19-99			18-101		

*FY2003 funding, enrollment, and age ranges represent total program counts.

NOTES:

GF = General Fund

HHA = Home Health Agency

HBW = Home Based Services Waiver

ASP = Attendant Service Program

PATH = Department of Prevention, Assistance, Transition and Health Access

NH = Nursing Home Level Criteria

Building on the popularity of the ASP, the state added a Medicaid state plan component to the ASP in 2002, which also provides consumer-directed personal care services. Eligibility is based on the higher functional criteria of two or more limitations to qualify. The Medicaid covered ASP participants may not hire their spouses as attendants.

Services under both the state general fund and Medicaid ASP options are capped at 13 hours per day. Service needs for both parts of the ASP are assessed by the 12 regional home health agencies which contract with DAIL to conduct the assessments. Hours of service are determined by the ASP eligibility committee which is comprised of at least two program participants and a DAIL staff member. The committee reviews assessments and awards a specific number of service hours per day for each program participant. The program participant members receive a per diem payment for the time they spend in committee meetings. DAIL acts as the intermediary service organization which manages the payroll and insurance benefits and sets the wages.

Vermont also offers self-directed options under their Medicaid home and community-based waiver. This waiver offers personal care services that are directed by home health agencies, consumers or surrogates. Participants using this benefit must qualify for nursing facility level of care and be eligible for Medicaid long-term care services. In addition to personal care services, this benefit also provides respite, case management (CM), adult day services, personal emergency response services (PERS), assistive devices, home modifications, and companion services. Service levels are based on need. Spouses may not be caregivers under this benefit but other family members and friends may.

In all three components of the waiver program, DA&D contracts with 10 Designated Administrative Agencies (DAAs) to provide certain administrative functions. These DAAs may be either AAAs or certified Home Health Agencies. They manage the waiver waiting lists in each area, perform outreach and preliminary assessments, and work with waiver teams in the field to prioritize cases.

There are 12 waiver teams each covering a certain region of the state. These teams manage the waiver waiting lists and allocate the local 'slots' through a prioritization process. Each team is comprised of 6-12 members representing AAAs, home health agencies, adult day centers, local hospital and PATH (Medicaid) offices, as well as residential care homes, mental health, housing, and transportation. Waiver teams also conduct active outreach to promote the HCBS waivers and develop close working relationships with partners in each region.

The various consumer-directed programs are similar in many ways. In each, the participants or their surrogate (rather than a home health agency) are the employers and are responsible for recruiting, screening, hiring, training, scheduling, supervising, and terminating

their caregivers.² They also are responsible for their timesheet management. Under the waiver, the participants must be certified annually by case managers to determine current ability for self-directing care. Their certification depends on their abilities in the following domains:

- Communication and decision making
- Knowledge of disability and related conditions
- Knowledge of personal assistance needs
- Ability to employ personal care attendants
- Ability to follow program requirements once in the program

Vermont sets personal care and respite care wages for personal care attendants in both the state-funded and Medicaid-funded consumer-directed programs. Payment rates in the ASP program are generally lower (\$8 an hour increasing to \$8.50 after 6 months) than in the waiver program (\$10 an hour) (*Figure 3*). Consumer-directed personal care attendants are entitled to unemployment insurance and worker's compensation, but not health insurance, vacation, or sick leave pay. Back-up coverage is only available if participants hire additional caregivers or if the home health agency can provide backup services.

B. Client Access

Older adults and younger persons with disabilities enter the community-based ASP and Medicaid home and community-based waiver programs through the five regional AAAs, the 12 regional home health agencies, PATH district offices, nursing home and hospital discharge planners, physicians' offices, the Vermont Center for Independent Living and adult day centers. Once it is determined whether the individual is seeking ASP or Medicaid waiver services, he/she is referred to the appropriate organization (*Figure 4*).

ASP applications are sent to the DA&D for approval. These applications are forwarded to one of the 12 HHAs for a clinical assessment. If the individual is applying for Medicaid covered ASP services, DA&D checks PATH records to determine if the person is eligible for Medicaid. Services are authorized by the ASP eligibility committee who reviews the assessment and awards the appropriate number of hours. If funds are not available, the case is assigned to a waiting list. As of March 2003, the ASP had a waiting list of about 250 people.

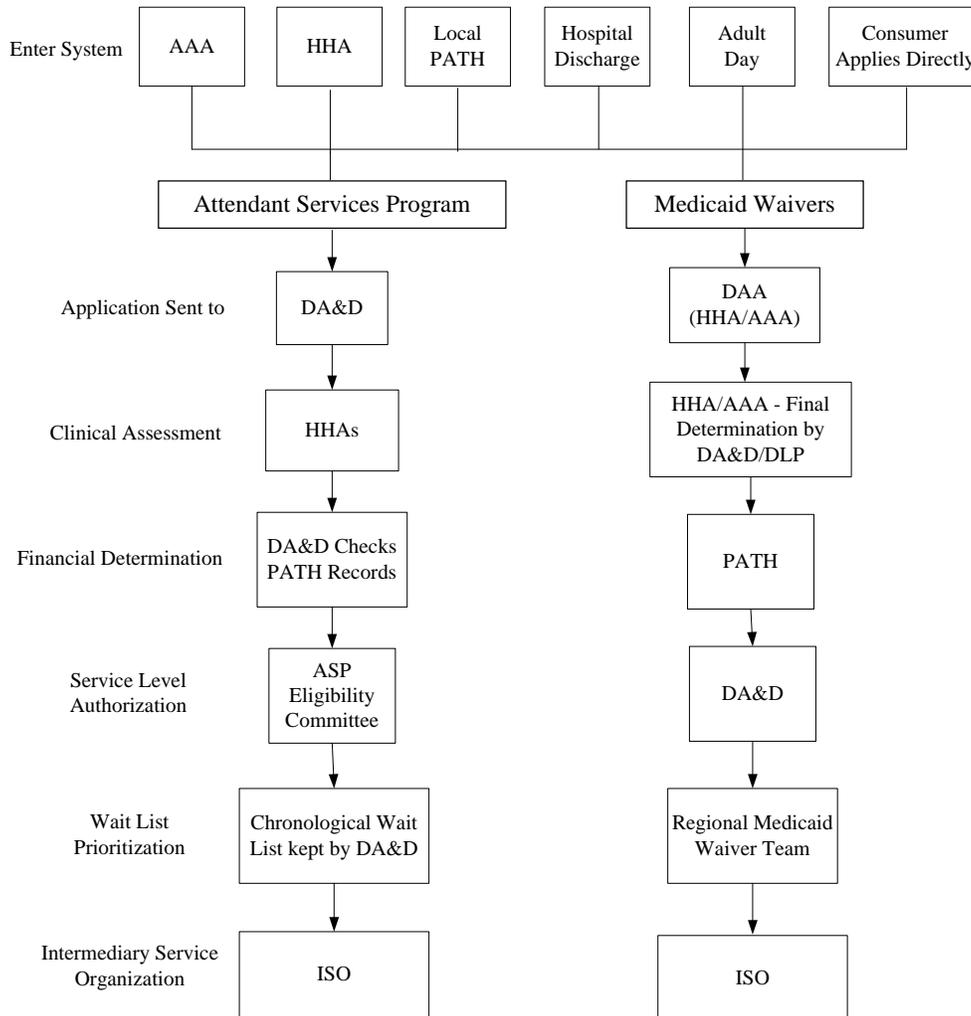
² The AAAs or regional HHAs may assist the employers in searching for personal care attendants to hire.

Figure 3
Comparison of Attendant Services Program versus Home and Community-Based Medicaid Waiver

<u>SERVICES/FEATURES</u>	<u>ATTENDANT SERVICES PROGRAM</u>		<u>MEDICAID HOME AND COMMUNITY-BASED WAIVER</u>	
	<u>Consumer-Directed Services</u>	<u>Home Health Agency (HHA) Services</u>	<u>SERVICES/FEATURES</u>	<u>Consumer-Directed Services</u>
Funding Source	State general revenue Medicaid state plan	Medicaid waiver	Funding Source	State general revenue Medicaid state plan
Employ spouse	Yes (State-funded program only)	No	Employ spouse	Yes (State-funded program only)
Employ other family member(s)/friend(s)	Yes	Yes (dependent upon HHA hiring the person)	Employ other family member(s)/friend(s)	Yes
PCA Rates*	\$8-\$8.50/hour	\$24/hour*	PCA Rates*	\$8-\$8.50/hour
Payroll managed by	DA&D	Local Home Health Agency	Payroll managed by	DA&D
Unemployment insurance/workers' comp	Yes	Yes	Unemployment insurance/workers' comp	Yes
Vacation or sick leave/pay	No	Rarely (depends on HHA policy)	Vacation or sick leave/pay	No
Health insurance	No	Rarely (depends on HHA policy)	Health insurance	No
Standby/backup coverage	Available if participant/agent is able to hire additional caregiver(s)	Variable (depends on HHA staff availability)	Standby/backup coverage	Available if participant/agent is able to hire additional caregiver(s)

* Includes Provider Tax.

**Figure 4
Vermont Client Flow Chart**



Under the Medicaid home and community-based waiver program, applications follow a slightly different path. This population must meet nursing home level of care guidelines to qualify for any services, including agency, consumer, and surrogate directed. Applications for the waiver program are sent directly to the Designated Administrative Agencies (DAAs) for the waiver services. The DAA helps participants select a case management agency; either a AAA or Home Health Agency. A case manager from that agency then conducts the assessment and submits it to the DA&D for clinical review. As in the ASP, financial applications for long-term care Medicaid eligibles are submitted to PATH.

Service levels are approved under the waiver program by DAIL waiver staff. If no waiver slots are available in a particular area, the DAA adds the consumer's name to the priority waiting list which is managed by the local waiver team. The waiver program had a waiting list of just under 40 people as of March 2004. These lists are much shorter than ASP's because the acuity levels of many of these cases is quite high and contributes to high turnover rates (50 percent). Also, DA&D has been able to add at least 100 waiver slots each year since 1996, making the program more accessible.

Some clients terminate because they have died at home with available waiver services while others terminate to enter a nursing home or an Enhanced Residential Care Home because of increasing care needs.

Under both the ASP and Medicaid waiver options, the state contracts with an intermediary service organization to manage the payroll and related administrative work.

C. State Sponsored Supports for Consumer-Directed Participants

The strength of Vermont's consumer-directed programs is in the support system the state provides to clients, caregivers, and the system in general. This system is three-pronged and addresses fiscal management, employee management, and workforce retention issues.

First, Vermont uses a fiscal intermediary model which means the state contracts with an intermediary service organization (ISO) to:

- certify consumers as employers
- provide payroll assistance and other fiscal intermediary services
- check criminal records and abuse registries
- assist with employer administrative functions such as tax withholding, payments and wage reporting issues, unemployment and workers' compensation insurance.

The state also developed a handbook for the consumer and surrogate directed Medicaid waiver services. This handbook presents information on enrolling in the programs, including the eligibility requirements, employer responsibilities, and program limitations. It also describes the personal care, respite, and companion services available. In addition, the handbook covers employee management issues, such as employee recruitment, worker eligibility criteria, and payroll policies and procedures. It provides direction on issues such as timesheet submissions, worker replacements, terminations, and problems with payroll or fraud. The last section of the handbook discusses the role of the case manager under the Medicaid waiver programs – their

responsibilities and limitations. It provides information on abuse, neglect, and exploitation including their definitions and who to contact if these issues are suspected. Contact information for all the local administrative agencies and AAAs is provided. The workbook also includes the forms used in these programs.

The third leg of the state's support system involves the caregivers. As mentioned earlier, the state is using its Real Choice Systems Change grant and related Robert Wood Johnson funding to contract with the COVE consumers advocacy organization to develop a professional care provider association. This association is expected to help retain personal care attendants by creating an association they can use to access information and training and raise concerns.

III. KEYS TO SUCCESS

Vermont redesigned its long-term care policies during the 1990s to create a more balanced system that allowed consumers more choices. The state built on its consumer-directed models which had been driving personal care options since 1980. Legislation passed in 1996 (Act 160) boosted these efforts further by requiring the DA&D to earmark dollars "saved" from lower nursing home utilization to invest in home and community-based alternatives.

Having a previously successful consumer-directed option such as the ASP was useful but not necessary for building this community-based option. Similarly, a waiver was not required to establish a successful consumer-directed program either. Much of Vermont's success is due to having a multitude of factors in place:

- Clients interested in consumer-directed service options;
- A good set of screening tools, especially those that determine a client's competency to self-direct care;
- Training for case managers who perform screenings and certifications;
- Local, well-functioning waiver and ASP eligibility teams to oversee local needs and program use;
- Payment rates for personal care attendants set high enough to attract caregivers and be competitive with the rates home health agencies offer;
- Flexible schedules and competitive rates which allow consumer-directed options to tap into a different segment of the workforce than that traditionally drawn upon by HHAs;
- A competent, reliable, well-trained intermediary service organization, with committed staff ready to work with frail elders and younger adults with physical disabilities, to provide constant phone support, help with tax forms and other paperwork;

- Regular surveying of participants to measure satisfaction with the program (90 percent of consumer directed options participants in Vermont report being satisfied with the services they receive).

The ASP was created because of strong advocacy from the disability community as part of their efforts to assist severely disabled individuals to return to work. The program has broadened its scope over time to serve elders and other individuals who do not have work-related needs. It served as a model for the consumer-directed option that is now provided through a Medicaid home and community-based waiver.

Second, both older and younger consumers demanded the opportunity to hire people they knew to provide personal care services. Part of this may have been in response to workforce shortages home health agencies were experiencing as they were unable to hire enough personal care attendants to serve the Medicaid waiver program as well as strong consumer preference.

Third, the Department of Aging and Disabilities was looking for ways to meet consumer demand and save program resources. Once the consumer-directed programs were operational, DA&D realized significant savings in comparison with contracting for traditional agency-based services³. As a result, the state was able to increase the number of personal care hours available with the same amount of funding. Administrative costs formerly borne by the agency are now absorbed by the consumer.

Because Vermont is a rural state with limited numbers of providers, DA&D considers it very important to ensure that both agency-based and consumer-directed options continue to be available. Rates in both the consumer-directed and agency-based programs are set so that the payments for the state's 12 home health agencies are high enough to ensure their continued participation in the waiver and to ensure that participants can hire quality caregivers. Further, the relatively high rates DAIL pays for personal care attendants in consumer-directed programs are intended to encourage HHAs to pay their staff competitively.

The programs have a good reputation in the state and thus far, Adult Protective Services has received few if any complaints or reports about the program's participants. In fact, surveys of participant satisfaction repeatedly give the program high ratings.

³ In consumer-directed program a personal care attendant is paid \$10 an hour; under Medicaid waiver contract, DA&D pays HHAs about \$24 per hour of personal care service. (Rate include Provider Tax component.)

Many factors contributed to the success of these programs. Vermont has taken a single state-funded program, expanded its Medicaid state plan and home and community-based waiver to complement the state program, and is securing additional private foundation resources to further strengthen the state's efforts. This program is a good example of expanding limited resources by coordinating multiple funding streams while building on existing programs and reaching rural populations to allow them to remain in their homes and age in place.

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Web Resources

Vermont Department of Prevention, Assistance, Transition, and Health Access (PATH)
<http://www.dsw.state.vt.us/>

Vermont Department of Aging and Disabilities (DA&D)
<http://www.dad.state.vt.us/>

Division of Advocacy and Independent Living
<http://www.dad.state.vt.us/dail/>