



Vermont Developmental Disabilities Council

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For the record, my name is Kirsten Murphy and I am the Executive Director of the Vermont Developmental Disabilities Council (VTDDC).

DD Councils exist in every state, territory, and jurisdiction in the country. We were created in federal law and in Vermont, we are solely funded by a federal appropriation. Congress created DD Councils to ensure that people with developmental disabilities and their family members have a strong voice in the development of policies that will impact their service and ultimately their quality of life. I report to a public board that is made up of 60% people with developmental disabilities and family members representing every corner of Vermont, literally Swanton to Brattleboro, Bennington to Derby Line.

Thank you for the opportunity to share some information with you today. The purpose of my testimony is to provide some context for the changes to case management services required by federal Medicaid Rules. (I will refer to these as the HCBS Rule). When Congress created the national network of DD Councils, it did so with the understanding that vision embedded in landmark bills like the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA) would not be realized unless organized self-advocates and family members advocated for robust implementation. Revisions to the HCBS Rule are a clear example of this.

Background

On March 17, 2014, the Centers for Medicare and Medicaid (CMS) formally adopted new rules for the delivery of home and community-based services (HCBS). For more than a decade, CMS had been granting waivers under several authorities to states that wanted to build community-based programs for recipients of long-term services and supports as an alternative to institutional settings. But, CMS had not until 2014 defined what “community-based services” must look like if they are to be funded by Medicaid. This sets the HCBS rules apart as far more important than simply tinkering

with regulations. National networks like that of the DD Councils were advised to make vigorous implementation of the HCBS rules a priority in our states.

In fact, Vermont advocates were well aware of what was at stake in the new rules. Outreach Coordinator Max Barrows was among the self-advocates that developed a white paper at the request of the Administration on Community Living that had significant influence on how CMS crafted the HCBS Rules. *Keeping the Promise, Self-Advocates Defining the Meaning of Community Living*, speaks to the fact that authentic community living is characterized by the quality of life a person enjoys, not by the type of building one lives in. Personal choice and control are critical to that quality of life.

What the HCBS Rule Requires

The HCBS Rules fall into two categories. One has to do with the types of settings where services take place. The gist of this part of the Rule is that services delivered in certain group or “congregate” settings may not, without special exceptions, be reimbursable by Medicaid. The current administration has pushed the implementation deadlines for this part of the HCBS Rules out to 2022.

The other section of the HCBS Rules focuses on service planning and the need to deliver services without “undue conflict of interest.” This part of the Rule was effective almost immediately upon adoption. In other words, it has been a requirement since 2014. Vermont is possibly the last state, or among the last, to develop a plan for compliance.

Specifically, the Rule requires that:

- providers of HCBS for the individual must not provide case management activities or develop the person-centered service plan [42 CFR 441.301(c)(1)(vi)].
- The State Medicaid Agency (SMA), which is the Agency of Human Services in Vermont, is responsible for eligibility determinations, and eligibility determination can only be delegated to another governmental agency with SMA oversight [42 CFR 431.10].
- Case management activities must be independent of service provision. An entity, agency or organization (or their employees) cannot provide both direct service and case management activities to the same individual except in very unique circumstances set forth in regulation.

The impetus for reducing conflict is the desire on the part of CMS to uphold the central place that person-centered planning has in the delivery of HCBS. The specific problems that CMS is seeking to address are:

- Steering. This refers to instances when an agency might direct an individual to a specific service or service provider that is relatively convenient or familiar to the agency. For example, a designated agency might fail to mention that an individual has the option of having their services delivered by a specialized service agency that also operated in their region.
- Self-policing occurs when an agency or organization is charged with overseeing its own performance. For example, a case manager may overlook a home provider's failure to file required paperwork because they are colleagues or because the case manager is aware of how difficult it would be to find a replacement home provider.
- Fiduciary conflicts of interest can contribute to a host of issues, including incentives for either the over- or under-utilization of services and possible pressure to retain the individual as a client rather than promoting choice, independence, and requested or needed service changes.

On two occasions, the Vermont DD Council met with AHS officials and on both occasions, public members of the Council gave multiple examples from their personal experience where each of these types of conflicts of interest have occurred and negatively impacted their ability to address quality concerns or exercise informed choice. This does not necessarily represent everyone's experience, but it does indicate that for some people served by the system there are genuine concerns that need to be addressed.

The Council's concern is reinforced by some of the findings in the 2017-18 National Core Indicators In-person Survey:

- In response to the question "Can change their case manager/service if they want to," Vermont scored in the "significantly below average category," with 81% of respondents indicating "yes" compared to the national average of 89%.¹
- In response to the question, "Case manager/service coordinator asks person what s/he wants," Vermont scored below the national average, with 83% of respondents indicating "yes" compared to 88% nationwide.²

¹ National Core Indicators, In Person Survey, 2017-18, page 52. [See: https://www.nationalcoreindicators.org/upload/core-indicators/17-18_IPS_National_Report_PART_I_3_20_19.pdf](https://www.nationalcoreindicators.org/upload/core-indicators/17-18_IPS_National_Report_PART_I_3_20_19.pdf)

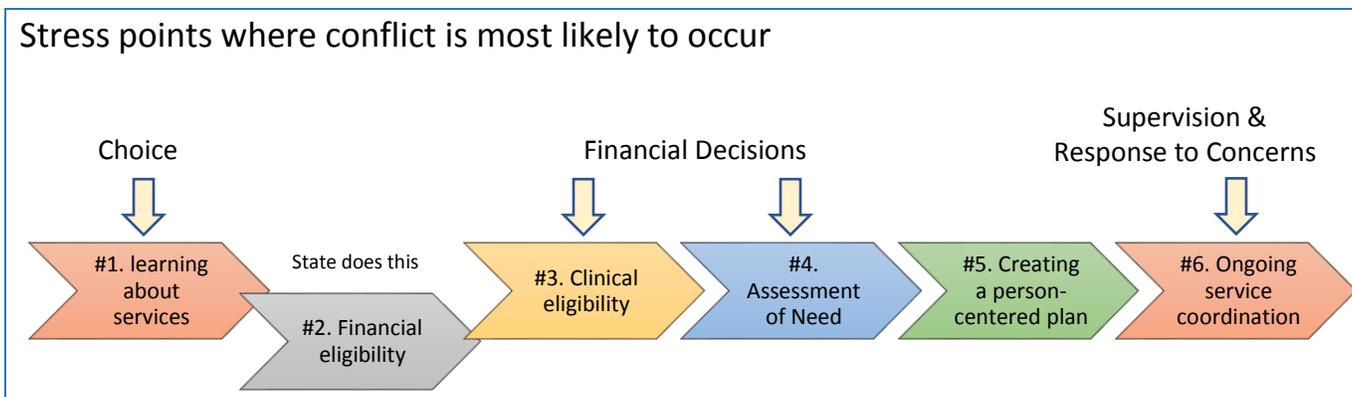
² Ibid., page 146

- In response to the question, “Person was able to choose services they get as part of service plan,” Vermont was in the “significantly below average category,” with 68% of respondents indicating “yes” compared to the national average of 79%.³

The Council acknowledges that Vermont has been an early and successful adopter of many best practices in the delivery of person-centered, individualized services, something for which the State is rightly proud. Certainly, there are other core indicators that speak well of Vermont’s performance. However, this does not negate the fact that decision-makers in the Vermont DS System can be swayed by unconscious bias and misaligned financial incentives.

Case Management in Vermont

Unfortunately, one thing that CMS did not define in the new Rule was the meaning of “case management,” an activity that has come to mean different things in different states.

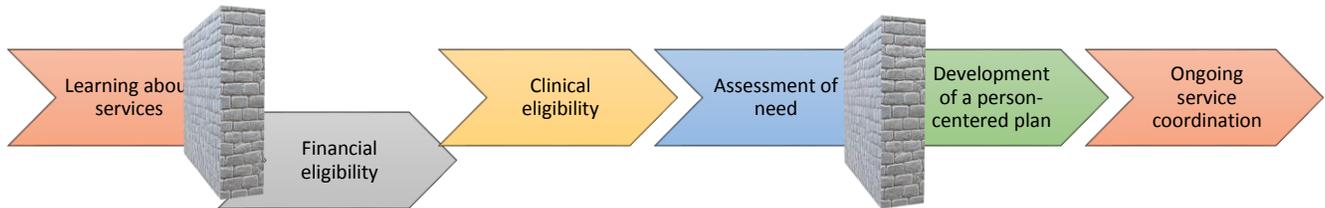


Case managers in Vermont are engaged in a wide range of activities. These may include initially “onboarding” a new service recipient, coordinating assessments, facilitating person-centered planning sessions, screening and hiring direct support staff, recruiting home providers, and troubleshooting as service gaps and other needs arise. They act as “gate keepers” to DS funding, other public benefit, and even medical care, especially when complex arrangements need to be made. Typically, case management also includes quality assurance activities – for example, evaluating direct support providers, conducting site visits, and fielding concerns from service recipients, home providers, and staff. Case managers even step in to provide direct care or transportation when front-line staff are unavailable. This integrated, agency-based

³ Ibid., page 158.

approach was fully intentional, representing the State’s best thinking at the time the Developmental Services System was designed.

Slide 2 illustrates some of the steps that the State must make in response to the Rule.



- The State, not designed agencies, will directly contract for clinical eligibility determination and for an assessment of need.
- The State must also tease apart case management services that support service planning, quality assurance, and oversight of the implementation of a service plan, from service coordination activities like hiring and training staff. The latter may remain at the agencies while the former must either be moved or be permitted to remain at the agencies by an exemption to the Rule.
- The State is currently deciding whether to seek an exemption or a partial exemption. To date, exemptions have been rare and very limited in scope.

In closing, we would like to say that no single mechanism will by itself bring Vermont into alignment with the Rule. The Council has provided AHS with a robust set of recommendations, and we hope we can share some of these ideas with you in the future. The State has a duty not only to comply with the letter of the law, but to embrace the principles that have given rise to this requirement – informed choice, effective checks and balances, and the separation of financial decision-making from service planning and delivery.

Thank you for your time and for your service to Vermont,

Kirsten Murphy
Executive Director