

**Report to the Vermont General Assembly
House Committee on Human Services
Senate Committee on Health and Welfare**

**2009 Act 25 Sec. 17.
EXPANDED SIMULTANEOUS ELIGIBILITY
FOR
CHOICES FOR CARE AND HOSPICE**

January 2010

**Submitted by:
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Agency of Human Services
Department of Disabilities, Aging & Independent Living**



1. Purpose

This report is submitted to the Vermont Legislature, as required by Act 25 Section 17 of 2009:

“ELIGIBILITY FOR CHOICES FOR CARE AND HOSPICE CARE. The department of disabilities, aging and independent living shall investigate the feasibility of allowing Vermonters to receive services under the state’s Choices for Care program while also receiving hospice benefits under Medicaid or Medicare. No later than January 15, 2010, the department shall report its findings and recommendations regarding simultaneous eligibility to the house committee on human services and the senate committee on health and welfare.”

This report describes the background for this request, a brief description of hospice and Medicaid personal care services, and the history of ‘simultaneous eligibility’. The report ends with findings, conclusions and recommendations.

2. Background and Statement of the Problem

The stated purpose of the Division of Disability and Aging Services is to support older Vermonters and Vermonters with disabilities to live as they choose, pursuing their individual goals and preferences within their chosen communities. The Choices for Care program allows people to choose services from a variety of settings and options, including services to people in their own homes. In providing long-term care to people living in their own homes, family members and friends often provide unpaid care and support.

Vermonters who are terminally ill typically want to die in their own homes, surrounded by their friends and family members. Vermont’s hospice programs are the primary resource in supporting people with terminal illnesses during their final days at home. Most hospice funding comes from Medicare. In providing care to people living in their own homes, hospice programs also routinely rely on family members and friends to provide core voluntary support. Some of Vermont’s hospice providers require family caregivers to be available before enrolling a person with a terminal illness into hospice services. In the absence of this unpaid support from family and friends, in-home hospice services are sometimes unavailable or inadequate. This means that some people must then move to nursing homes to die. Three groups of people face this prospect:

1. People who live alone, with no family caregivers available;
2. People who have family caregivers who are aged or frail, and unable to provide adequate support;
and
3. People who have family caregivers who work, and unable to provide adequate support during working hours.

Because Choices for Care is the primary source of Medicaid personal care services in community settings in Vermont, hospice providers sometimes look to Choices for Care to “stand in” for family caregivers or to “supplement” family caregivers. This has led to renewed interest in allowing Vermonters who enroll in hospice to simultaneously enroll in Choices for Care.

3. Description of Programs

A. Hospice

Hospice services under Medicare provide care and support to people who are terminally ill, as well as providing support to their families. These services help people with terminal illness live out the time they have remaining to the fullest extent possible. "Terminally ill" is defined as having a prognosis of six months or less to live if the illness runs its normal course. Hospice care is given in "periods of care". Individuals can receive hospice care for two 90-day periods followed by an unlimited number of 60-day periods.

Hospice care is provided by a specially trained team that cares for the "whole person," including physical, emotional, social, and spiritual needs. The team also helps family members cope with the death of their loved one- before, during, and after death. Medicare defines "hospice care" to include the following items and services provided to a terminally ill individual by a hospice program under a written plan:

- (a) Nursing care provided by or under the supervision of a registered professional nurse;
- (b) Physical or occupational therapy, or speech-language pathology services;
- (c) Medical social services;
- (d) Home health aide and homemaker services;
- (e) Medical supplies (including drugs) and the use of medical appliances;
- (f) Physicians' services;
- (g) Short-term inpatient care including both respite care and procedures necessary for pain control and symptom management in an inpatient facility (respite care may be provided only on an intermittent basis and may not be provided consecutively over more than five days); and
- (h) Counseling (including dietary counseling) regarding the care of the terminally ill individual and adjustment to the individual's death.

Social Security Act, Title 18, Section 1861(dd). Under Medicare hospice regulations (42 CFR § 418.76), the duties of a hospice aide include the following:

- (a) The provision of hands-on personal care;
- (b) The performance of simple procedures as an extension of therapy or nursing services;
- (c) Assistance in ambulation or exercises; and
- (d) Assistance in administering medications that are ordinarily self-administered.

Hospice services must be provided by a Medicare certified hospice in accordance with Medicare regulations and conditions of participation. While hospices are neither expected to nor prohibited from fulfilling the primary caregiver role for an individual, in practice hospice care is generally used to supplement the voluntary care provided by the individual's family and friends. The hospice is required to provide home health aide and homemaker services in an amount that, in combination with family support and other services, is adequate to meet the needs of the individual. These needs are determined by the hospice interdisciplinary team, and are addressed through the hospice plan of care. This written plan must be established and periodically reviewed by the individual's attending physician, by the hospice medical director, and by the interdisciplinary team. Nursing care and home health aide services may be provided

on a 24-hour, continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home.

When people elect to receive hospice, they are required to “waive” other Medicare services with the exception of a designated family physician, ambulance services, and services unrelated to the terminal illness. The hospice may not charge any amount to or collect any amount from the recipient or the recipient’s family for a covered hospice service during the period of hospice coverage.

In 2006, Vermont hospice providers served 1,293 people under Medicare. In 2007, Vermont hospice providers served 1,416 people under Medicare. In 2007, the Hospice and Palliative Care Council of Vermont reported that 75% of the people served by Vermont hospice providers were supported by Medicare. This means that nearly 2,000 people per year are now served by Vermont hospice providers.

In 2006, the average Medicare hospice length of stay in Vermont was 55 days, compared to 69 days for the United States. In 2008, the average Medicare hospice length of stay in the United States increased slightly to 69.5 days, while the median length of stay was 21.3 days. This means that half of the people were served for three weeks or less, while a small percentage were served for many months.

B. Personal Care: Global Commitment and Choices for Care

States are given the authority to define the Medicaid services that they will provide, including a variety of ways in which personal care services are delivered. In practice, Medicaid personal care is similar to hospice, in that it is commonly used to supplement but not replace care otherwise provided by the individual’s family and friends. Some states provide personal care services under a “Medicaid State Plan”. Some states provide personal care services under Social Security Act Section 1915 Medicaid Waivers. Vermont provides all Medicaid services, including personal care, under two Social Security Act Section 1115 Medicaid Waivers: Global Commitment and Choices for Care.

(a) Global Commitment

Under Global Commitment, Vermont provides a Medicaid personal care benefit in two ways: Children’s Personal Care Services and Participant-Directed Attendant Care Services. Individuals participating in these programs must be eligible for Medicaid without using long term care clinical or financial eligibility rules.

Children’s Personal Care Services are provided only to people under the age of 21, as defined in Vermont Medicaid Rule 7406:

Personal care services are services related to a recipient’s physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, and taking medications. Services are provided to enable a recipient to remain in his or her home/community, maintain their current health status and prevent, delay, or minimize deterioration of their condition. Personal care services are intended to supplement care provided by a recipient’s family or primary caregiver, not replace it. Services may be provided in the home or in settings outside the home, when necessary.

Participant-Directed Attendant Care serves individuals over age 18 and provides physical assistance with activities of daily living and instrumental activities of daily living. To be eligible, individuals must have a permanent and severe disability, need assistance with at least two activities of daily living, and be capable of directing his or her attendant care services (including serving as an employer to hire, train, schedule, supervise, and terminate attendants.)

(b) Choices for Care

Choices for Care provides a range of long term care service options including Nursing Homes, Enhanced Residential Care Homes, PACE, and in-home services. Clinically, individuals must meet nursing home level of care, and they must be financially eligible for Medicaid under long term care eligibility rules. In the home setting, Choices for Care provides a variety of services. The following services are utilized by those who are on CFC and then become eligible for hospice services:

- Case Management
- Adult Day Services
- Personal Care
- Personal Emergency Response Systems
- Respite or Companion Care
- Assistive Devices
- Home Modifications

Personal care services are defined as services that “assist individuals in the home-based setting with activities of daily living (ADL) and instrumental activities of daily living (IADL) that are essential to the health and welfare of the individual.” This includes assistance with activities of daily living that is similar to the assistance provided by home health aides:

- Dressing
- Bathing
- Personal Hygiene
- Bed Mobility
- Toileting
- Assistance with Adaptive Devices
- Transferring
- Mobility
- Eating

Under Choices for Care, personal care also includes limited assistance with instrumental activities of daily living:

- Meal Preparation
- Medication Management
- Using the Telephone
- Money Management
- Household Maintenance
- Light Housekeeping
- Laundry
- Shopping

- Transportation
- Care of Medical or Adaptive Equipment

In SFY2008, about 2,000 people were enrolled in the Highest and High Needs Groups and served through Choices for Care in their own homes. This does not include people served by Choices for Care under the Moderate Needs Group.

4. History of Simultaneous Eligibility for Hospice (Medicare) and Choices for Care (Medicaid)

A. Federal History

Medicare is a federal health insurance program for seniors and for some people with disabilities, covering about 40 million citizens. Medicaid programs are unique to each state, i.e. each state designs its own Medicaid program including the income and resource requirements for eligibility, the services that will be covered, provider standards, and reimbursement rates, supported by different levels of federal matching funds. Under federal statute and regulation, Medicare is the primary payor for services, and Medicaid is the secondary payor. People access Medicaid benefits only when they are (a) ineligible for Medicare, or (b) require a service that is not available under Medicare but is available under Medicaid. Medicaid is the payor of last resort, and utilized only after Medicare and exhaustion of private insurance.

The Omnibus Budget Reconciliation Act of 1990 modified the Medicaid statute relating to hospice services. Prior to OBRA 90, when a Medicaid eligible individual elected the Medicaid hospice benefit, he or she waived the right to Medicaid payment for services other than those identified as covered hospice services: nursing care, medical social services, physicians' services, counseling services, home health aide services, homemaker services, medical appliances and supplies, and physical and occupational therapy. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or enable the individual to maintain activities of daily living and basic functional skills. As modified, the law allowed an individual to receive payment for Medicaid services related to the treatment of the terminal condition and other medical services that would be equivalent to or duplicative of hospice care, so long as the services would not be covered under the Medicare hospice program. This meant that Medicaid could now cover certain services which Medicare would not.

To prevent duplication of services, it has been up to each State to define the Medicaid personal care services benefit and to determine if the benefit is more extensive than the combination of home health aide/homemaker/volunteer services provided under the Medicare hospice benefit. If the Medicaid personal care service is more extensive than what is offered under hospice, then the State is obligated to pay for these services when an individual has a need for such services. If the Medicaid personal care service is less extensive than what is offered under hospice, then the State is not obligated to pay for these services. In addressing the simultaneous use of hospice and Medicaid services, the historical policy of many states was based on the perspective that personal care services are equivalent to the combination of home health aide and homemaker services under the hospice benefit- making hospice the primary and only service provided to the person.

In April 2001, CMS issued guidance (S7C 01-13) to the Hospice Association of America in response to the question "May a Medicare hospice patient also receive support services through a State's home and community-based care program?" CMS responded that if the individual is dually eligible (for both Medicare and Medicaid) and is a waiver recipient, he/she can elect the Medicare hospice benefit and continue to receive waiver services as long as the services are not equivalent to Medicare services. CMS

also stated that Medicaid should not pay for a service that is otherwise provided under the Medicare hospice benefit. This left the states with the responsibility of determining if and how hospice services differ from its Medicaid waiver services. Many states continued to deny simultaneous enrollment in hospice and waiver services.

In May 2008, CMS issued revised rules and regulations regarding Hospice services. At that time commenters addressed the relationship between hospice aide services, hospice homemaker services, and Medicaid personal care benefits. In response, CMS added new elements in the regulations. Section 418.76(i)(2) provides that services furnished under a State's Medicaid personal care benefit "may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care". Section 418.76(3) requires that a hospice coordinate hospice aide and homemaker services with the Medicaid personal care services "to ensure the patient receives the hospice aide and homemaker services he or she needs". This again has left states with responsibility for determining if and how hospice services differ from Medicaid personal care services. Many states continue to deny simultaneous enrollment in hospice and Medicaid personal care services.

B. Vermont History

For decades, Vermont Medicaid policy precluded people enrolled in hospice from receiving most other Medicaid services- including Medicaid home health services and aged/disabled waiver services. Current Vermont Medicaid Hospice Service regulations (Rule 7402) were established in 1987 and state:

Existing Medicaid recipients of hospice care are required to sign an election of hospice care which waives all other Medicaid coverage except the services of a designated family physician, ambulance service and services unrelated to the terminal illness.

In recent years, DAIL staff and Vermont hospice providers have discussed the needs of Vermonters, including individuals with multiple and complex needs that may best be met through a combination of hospice services and Medicaid services, while avoiding duplication of services or shifting of costs from Medicare to Medicaid.

In 2000, DAIL policy was changed to allow individuals to simultaneously receive hospice and personal care services (attendant services or long term care waiver services) as an exception when the person's needs could not be met by hospice services alone, but could be met by a combination of services. Criteria were developed and case-by-case decisions were made by DAIL staff, based upon the person's individual needs and circumstances.

In 2004, just prior to the implementation of Choices for Care, DAIL met with hospice providers to review this policy and challenges. Two core challenges were identified:

- (a) Eligibility: the clinical and financial eligibility process for LTC Medicaid is complex, typically requiring 30-60 days, and sometimes much longer. Because the average length of stay in Vermont hospice programs is about 60 days, many people enrolled in hospice would not be able to complete this eligibility process before they die.
- (b) Service plans: The staff, assessment tools, and service plans used in hospice and Choices for Care differ- even within the home health agencies. Staff must sometimes wrestle with integrating services associated with terminal diagnoses together with services associated with

other, non-terminal diagnoses. As a result, creating integrated service plans requires additional time and effort, with additional delays.

Considering these challenges, in July 2005 DAIL revised its policy to allow participants who are already enrolled in Choices for Care, and have a terminal diagnosis, to simultaneously enroll in hospice. This change was made to allow continuity of caregivers through Choices for Care, while allowing access to comprehensive palliative care under hospice. Hospice services were expected to be the primary source of services, Choices for Care services were not expected to increase after enrollment in hospice. Note that this change in policy was “one way”: people already served under Choices for Care could add hospice, but people already served in hospice could not add Choices for Care. This was consistent with the Choices for Care Manual (Section II, Eligibility):

Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicaid and Medicare.

In September 2006, DAIL reiterated this policy in a memo to Home Health Agency Directors:

Since July 18, 2005, it has been the policy of the Department to allow participants of the Choices for Care program to enroll onto Hospice services without being terminated from the program. This agreement was dependent upon the home health agencies' assurance that Choices for Care services would not increase in cost after enrollment onto Hospice.

To further clarify, the existing Hospice Agreement does not include individuals who are currently receiving Hospice services and then subsequently apply to the Choices for Care program. At this point in time, the Department is not approving the Choices for Care program for individuals who are eligible for Hospice services at the time of their Choices for Care application. I know that we are jointly committed to ensuring that Vermonters are able to spend their final days at home if at all possible. To that end, we want you to keep us informed if the above procedure is not furthering that goal.

This policy and practice remains in effect today.

5. Findings and Feasibility

A. Context:

Based on the current fiscal climate, this report assumes that:

- It is reasonable for hospice programs to expect family and friends to provide voluntary care and support to their dying family members;
- It is not programmatically or financially feasible for the hospice programs to routinely reimburse family members and friends for the care and support they provide to their dying family members; and
- It is not financially feasible for Choices for Care to routinely reimburse family members and friends for the care and support they provide to their dying family members.

B. Simultaneous enrollment under current policy:

Because hospice enrollment/claims data cannot currently be compared to Choices for Care enrollment/claims data, the precise number of people who are served simultaneously under hospice and Choices for Care is unknown. Based on partial data submitted by hospice programs and secondary estimates by DAIL staff, in SFY2009 an estimated 30 to 70 people were enrolled in Choices for Care in the home-based waiver setting and were then simultaneously enrolled in hospice care.

C. Additional need for simultaneous enrollment:

In estimating the unmet need for simultaneous enrollment, as well as the cost and feasibility of meeting estimated needs, each subgroup must be operationally defined and the numbers of people falling into each subgroup must be estimated:

- People who live alone, with no family caregivers available, and are thus found ineligible for hospice: hospice providers do not currently collect and report these data.
- People who have family caregivers who are aged or frail, and unable to provide adequate support, and thus cannot be served successfully at home: hospice providers do not currently collect and report these data.
- People who have family caregivers who work and are unable to provide adequate support during working hours, and thus cannot be served successfully at home: hospice providers do not currently collect and report these data.

Several hospice providers were asked to estimate the number of people who could not be served successfully at home, and had to move to a nursing home to die. One of the largest providers estimated about two people per year, while one of the smallest hospice providers estimated about half of the people served by that agency. In the absence of data, a number of factors may contribute to the difference between the estimates, including:

- Different availability of family/friend caregivers
- Different availability of hospice volunteers
- Different financial pressures/constraints on hospice providers
- Different perspectives on “safety” in the home and the role of nursing home care

D. Palliative Care and Choices for Care

Staff in some areas of the state report that people who are dying commonly receive a combination of Choices for Care and palliative care services, which are separate and distinct from hospice. It is not clear how the benefits, outcomes, and costs experienced under this arrangement differ from those experienced through simultaneous enrollment in Choices for Care and hospice.

E. Feasibility of meeting unmet needs through simultaneous enrollment:

The legislation directs the department to investigate the “feasibility” of simultaneous enrollment. “Feasibility” may be considered through the following elements:

(a) Eligibility determination:

The Choices for Care application and eligibility process includes two elements: clinical eligibility and financial eligibility. The clinical process requires an assessment and review by a state Long Term Care Clinical Coordinator. The financial eligibility process requires the applicant to submit a financial application, which can be detailed and time-consuming, followed by a review by Department of Children and Families eligibility staff.

To determine the specific services that will be provided, the Choices for Care case manager must complete an assessment and submit a Plan of Care to DAILE for approval. This requires coordination with the individual, family members, and other providers, including hospice providers. As part of this process, DAILE staff seek to ensure that Medicare and private insurance benefits are fully utilized before Medicaid benefits, since Medicaid is the payor of last resort. This process of resolving the role of family and friends, Medicare hospice, and Choices for Care presents a host of challenges: philosophical, financial, and practical.

In total, the Choices for Care eligibility process now routinely requires 30-60 days. The national median length of stay in hospice is 21 days. This means that 50-75% of the people who are served by hospice will have died before their Choices for Care eligibility process is complete. This suggests that for many people served by hospice, Choices for Care is not likely to be a timely, practical, and feasible method of meeting unmet needs.

Some members of the Vermont Assembly of Home Health Agencies (VAHHA) estimate that approximately 40 people per year would be eligible for both hospice and Choices for Care. However, this estimate is based on subjective estimates from a subset of hospice providers. Hospice providers have not been able to produce data that describe the actual number of people that need expanded simultaneous eligibility. In the absence these data, it is not possible to accurately determine how many people with unmet needs would meet both eligibility criteria at the time that they need additional services. Estimates range from 2% to 20% of the people currently served by hospice.

(b) Service adequacy:

To improve outcomes for individuals, services must be provided in adequate type, amount, scope, and duration to meet currently unmet needs. This requires an adequate understanding of these unmet needs. Hospice providers have described a range of needs, from a few hours each day to a large number of hours each day. As described, some of these unmet needs would be beyond the current limits of practice for personal care attendants. Absent more clarity regarding the people whose needs are unmet and what those needs are, it remains extremely difficult to determine if and when Choices for Care could effectively meet those needs.

(c) Financial feasibility

Vermont state government is faced with the challenge of reducing expenses in SFY 2011 by approximately \$150 million. Choices for Care currently has a waiting list of approximately 70 people for the High Needs Group, and enrollment in the Moderate Needs Group is frozen. In this context, cost estimates are extremely important. Accurate cost estimates depend on accurate data regarding the numbers of people to be served, the types of services to be provided, and the volume

of services to be provided. Unfortunately, as noted previously, accurate data remains unavailable. In the absence of these data, high and low cost projections may be made. The annual cost estimates range from a low of \$546,546 to a high of \$8,583,080:

Low Estimate

<i>Estimated Service Needs</i>			
	<u>PCA</u>	<u>Respite/Companion</u>	<u>Case Mgmt</u>
CFC service	\$26.68	\$21.32	\$67.44
Rate/hour	4	4	0.1
Hours/day	\$106.72	\$85.28	\$6.74
Cost/day			
Cost total			
services/day	\$198.74		
<i>Assumptions</i>			
2,000	Estimated # of people served by hospice per year		
2.5%	Estimated % simultaneously eligible for Choices for Care		
50	Estimated # simultaneously eligible for Choices for Care		
55	Average hospice length of stay (days)		
2,750	Estimated total days of service		
\$198.74	Estimated cost per day for Choices for Care home based waiver services (PCA, respite/companion, case mgmt)		
\$546,546	Total estimated annual cost of expanded simultaneous enrollment		

<i>Estimated Service Needs</i>			
	<u>PCA</u>	<u>Respite/Companion</u>	<u>Case Mgmt</u>
CFC service	\$26.68	\$21.32	\$67.44
Rate/hour	6	10	0.25
Hours/day	\$160.08	\$213.20	\$16.86
Cost/day			
Cost total			
services/day	\$390.14		
<i>Assumptions</i>			
2000	Estimated # of people served by hospice per year		
20%	Estimated % simultaneously eligible for Choices for Care		
400	Estimated # simultaneously eligible for Choices for Care		
55	Average hospice length of stay (days)		
22000	Estimated total days of service		
\$390.14	Estimated cost per day for Choices for Care home based waiver services (PCA, respite/companion, case mgmt)		
\$8,583,080	Total estimated annual cost of expanded simultaneous enrollment		

6. Conclusion and Recommendations

There is a widespread belief that expanding simultaneous eligibility for hospice and Choices for Care would benefit some people. Accurate data remain elusive and core questions therefore remain unanswered. Until sufficient data from hospice providers are available, it is not possible to determine if expanded simultaneous eligibility for hospice with Choices for Care is financially feasible.

The Vermont Assembly of Home Health Agencies (VAHHA) propose that "...OVHA and DAIL run a pilot project in two to three areas with aggressive hospice programs and see what happens. We are confident that the cost to the state would be small but the benefit to the few people who qualify, great." While DAIL supports the concept of well-designed pilots, we conclude that the proposed pilots are premature due to the following considerations:

- (a) Without a clearer understanding of which people have unmet needs and what those unmet needs are, it is not possible to determine if Choices for Care is an appropriate and effective method of meeting those unmet needs. This requires additional data from the hospice providers.
- (b) Without a clearer definition of who would be served under this expanded eligibility and the improved benefits/outcomes that would be achieved, it is not possible to define who would be eligible to participate in such a pilot. This requires additional data from the hospice providers.
- (c) To produce valid and reliable results that are representative of the state, the pilot regions must be representative of the entire state. Variations in some practices among the different regions make it difficult to generalize results from a small number of regions "with aggressive hospice programs" to all other regions.
- (d) Under the federal terms and conditions for Choices for Care, Vermont does not have the authority to create such a pilot, including geographical limitations. While it may be possible to request an amendment to the terms and conditions to operate a pilot, such an amendment request must define the group that would be eligible for the pilot.

A. Step One: Collect additional data from hospice providers

To accurately assess the financial feasibility of expanded simultaneous eligibility, DAIL recommends that all of Vermont's hospice providers provide the following information to DAIL on a monthly or quarterly basis:

- (a) The number of people who are refused admission or unable to be served by hospice, including:
 - the reason they were refused admission or are unable to be served;
 - the unmet needs of these individuals;
 - the services that would meet the needs of these individuals; and
 - an estimate of their clinical and financial eligibility for Choices for Care.
- (b) The number of people who are admitted to nursing homes from hospice, including:
 - the reason they were unable to be served in their own home;
 - the unmet needs of these individuals;
 - the services that would meet the needs of these individuals; and
 - an estimate of their clinical and financial eligibility for Choices for Care.

DAIL is willing to provide technical assistance to hospice providers in developing specific data elements and methods of submitting the information. If hospice providers are unable to provide information, DAIL concludes that an accurate estimate of feasibility is not possible.

B. Step Two: Convene collaborative workgroup

As data are submitted to DAIL by hospice providers, DAIL recommends that a collaborative workgroup convene to review the data. DAIL recommends that this group include representatives from:

- Hospice and Palliative Care Council of Vermont
- Vermont Assembly of Home Health Agencies
- Bayada Nurses
- Area Agencies on Aging
- Vermont Health Care Association
- Community of Vermont Elders
- DAIL Division of Disabilities and Aging Services
- DAIL Division of Licensing and Protection

DAIL recommends that this group further explore both the benefits and feasibility of expanded simultaneous eligibility in hospice and Choices for Care and prepare a report that addresses the following items.

1. Define the outcomes that would be achieved by providing additional support services to people receiving hospice.
2. Define the characteristics of people who have unmet needs that could be met by Choices for Care and/or other services.
3. Estimate the number of people needing hospice services who also need additional support services.
4. Define the Choices for Care services that would meet these needs.
5. Estimate the number of people who are eligible for Choices for Care at their time of need.
6. Determine whether Choices for Care eligibility and service approval processes can be timely enough to meet their needs, and if necessary, methods by which these processes may be streamlined.
7. Develop a protocol by which staff can determine the specific type and volume of support services to be provided by hospice, family members, and Choices for Care. This includes the expected role of family members, the ability of hospice programs to serve people who live alone, and judgments regarding safety at home.
8. Estimate the increased workload for DAIL and DCF staff.
9. Determine whether other services would more effectively meet the unmet needs of Vermonters participating in hospice, and the estimated cost of such services. This may include fee-for-service palliative care, other existing services, or the creation of a new service with targeted eligibility criteria.
10. Make recommendations to the legislature.

References:

Office of Vermont Health Access, Medicaid Covered Services Rules, Hospice Services – Rule #7402
<http://humanservices.vermont.gov/on-line-rules/ovha/medicaid-covered-services-7100-7700/view>

Medicare Conditions of Participation for Hospice - 42CFR
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=16fe25383c61d4a5219cb0e97850353c&c=ecfr&tpl=/ecfrbrowse/Title42/42cfrv3_02.tpl

Vermont Choices for Care Highest and High Needs Manual
<http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-manual>

Services Used by Medicare Beneficiaries, 2006
<http://www.statehealthfacts.org/profileind.jsp?rgn=47&ind=338&cat=6>

DAIL Memorandum regarding Choices for Care and Hospice, September 2006
<http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-documents/choices-for-care-and-hospice%20memo>

Hospice and Palliative Care Council of Vermont, testimony to the Vermont legislature, 2008:
http://www.hpccv.org/legis_test102708.htm

Hospice & Palliative Care Council of Vermont, Director's Annual Report, December 2008
http://www.hpccv.org/2008_dir_report.htm

Hospice Facts and Statistics, Hospice Association of America, September 2009
<http://www.nahc.org/facts/HospiceStats09.pdf>

National Hospice and Palliative Care Organization, NHPCSO Facts and Figures: Hospice in America, 2009 edition
http://www.nhpc.org/files/public/Statistics_Research/NHPCO_facts_and_figures.pdf