Date	February 22, 2023	**Time**	1:00 – 3:00 pm EST
Location	PUBLIC REGISTRATION LINK: https://healthmanagement.zoom.us/webinar/register/WN_e1h2-BAkS3ecP2lSo_zBJQ		
Attendees			
Advisory Committee Members	☒ Bill Ashe ☒ Maxwell Barrows ☒ Belinda Bessette ☒ Michele Corrow ☒ Keith Grier ☒ Chandar Hall ☒ Jessica Leal ☒ Marlee Mason ☒ Nicholas McCardle ☒ Kirsten Murphy ☒ Traci Osterhoudt ☒ Lindsey Owen ☒ Gloria Quinn ☒ Thomas Rees ☒ Kate Reilly ☒ Christopher Rotsettis ☐ Marla Simpson ☒ Cinn Smith ☒ Nicole Villemaire ☒ Deborah Wesley ☒ Susan Yuan	**AHS Steering Committee Members**	☒ Dylan Frazer ☒ Conor O'Dea ☒ Wendy Trafton ☒ Tracy O'Connell ☒ Fran Hodgins ☒ Bard Hill ☒ Angela McMann ☒ Alexandra Nerenberg ☒ Jeffrey Nunemaker ☒ Dana Robson ☒ Eva Dayon
		HMA Staff	☒ Sharon Lewis ☒ Boyd Brown ☒ Samantha Di Paola ☒ Liz Preston

Connection or Zoom Meeting Issues?

Please email Liz Preston, lpreston@healthmanagement.com or Samantha Di Paola, sdipaola@healthmanagement.com and we will do our best to help.

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Meeting Goals

- Introduce Advisory Committee
- Share background on case management and conflict of interest
- Provide an update on COI project activities
- Seek feedback on stakeholder and outreach strategies

Meeting Agenda

- Welcome and Introductions
    - Agenda Overview, Reminders
    - Introductions: Advisory Committee Members
    - Steering Committee Members
- Background
    - Medicaid HCBS Case Management
    - Conflict of Interest
    - Questions and Discussion
- Vermont's Efforts
    - Goals for Vermont HCBS-COI
    - CMS Plan of Correction
    - Other related initiatives
    - Questions and Discussion
- Stakeholder Engagement
    - Communication: Email and Website
    - Assessment Phase
    - Action item: Outreach Ideas
    - Questions and Discussion
- Wrap-Up and Next Steps

Meeting Minutes

1. **Agenda Overview and Reminders:** Sharon reminded the panelists and attendees that all Advisory Committee meetings will be recorded and available to the public.

2. **Introductions:** The Advisory Committee introduced themselves:
    a. **Max Barrows** is a self-advocate on the autism spectrum. He works as an Outreach Director for Green Mountain Self Advocates. Max helped with the national effort in 2011 to create the definition of Community Living for self advocates. (CMS used this in writing the HCBS rules.) He believes in autonomy. Max wants people to make choices about their services, which sometimes requires more time and work. Max is worried about the lack of non-biased plain language about this important policy. He is also worried about people losing service coordinator relationships. Max also thinks it is important to make sure people understand facts and rumors about this change. He is excited about the opportunity for people to receive better services. He is also looking forward to having a neutral person to plan and work with.
    b. **Bill Ashe** was formerly the Executive Director of Upper Valley Services. He is also a family member of two young people who receive services. He hopes Conflict-Free Case Management in Vermont will be vibrant. Vermont's system is made up of a whole web of interconnected relationships, and all of them need to be valued. He believes changes to case management must be integrated carefully into the Vermont system.
    c. **Belinda Bessette** is the Director of Behavioral Health Services at Northwestern Counseling and Support Services (NCSS). She has worked for NCSS for 22 years mostly in the children's group. Now she works with adults. Belinda thinks it is important to pay attention to how language is used to describe things. She also values collaboration – people working together.
    d. **Michele Corrow** is director at Pride Support Services and the guardian of a woman receiving Developmental Disability services. Michele is the parent of a child who used to receive services. She has worked in many roles including direct support and service coordination. She has heard from people who are fearful of losing their long-time service coordinators. Michele is looking forward to better consistency, quality, and choice in services. She also hopes services will be reviewed for quality.
    e. **Keith Grier** is the Director of the Community Support Program for Washington County Mental Health Services. Keith has worked in the

Designated Agency system for 23 years. Keith has concerns about relationships. He feels we are experiencing fractures in relationships within the system due to COVID-19. He worries more change in the system can harm relationships further. He sees opportunity in this change for good things for the people he serves.

f. **Dar Hall** is on the Flexible Choices program in the Choices for Care program. She worked in community mental health for 12 years. Even though she has tried, she has never been able to access case management. As an adult with complex medical needs, she feels strongly about access to case management to help people navigate the system.
g. **Jessica Leal** is the Director of the Brain Injury Alliance of Vermont. A lot of the people she serves do not qualify for case management services but really need them. She is hopeful the state will be able to provide more services while also providing more choices and options.
h. **Nick McCardle** is the State Administrator from Bayada Home Health. He has experience working in several states with different approaches to the HCBS regulations. He sees this as an opportunity to strengthen Choices for Care. He is most concerned about workforce shortages. Nick worries about the problem of inconsistent choice around the state in part due to not enough workers.
i. **Kirsten Murphy** is the Executive Director of the Vermont Developmental Disabilities Council. The DD Council has been one of the most vocal advocates within the state in favor of the addressing conflict of interest, even before CMS published the federal rules. Kirsten worries about the revisionist history around this rule and how this has unfolded over the years. Her hope was for Vermont to find a creative way to put checks and balances into the system to protect the rights of people served without sacrificing the high-touch warmth provided to people seeking services.
j. **Traci Osterhoudt** is the Manager of long-term care and social services at Franklin County Home Health. She has worked in home health for over 20 years, 17 of which have been as a Choices for Care case manager. Traci is excited about having consistency across programs within case management. This has been lacking and will be beneficial. Traci has

concerns about workforce and service recipients losing access to the people they trust.

k. **Lindsey Owen** is the Executive Director and attorney at Disability Rights Vermont and has been with them for 10 years. Lindsey worries about the silos they currently have in the system and the barriers to access. As a member of multiple advisory groups, she is hopeful this group can tackle the quality and accessibility of services with enthusiasm.
l. **Gloria Quinn** is the Executive Director at Upper Valley Services and has served people with developmental disabilities for 40 years. She is concerned that people with disabilities will lose resources and supports that are needed. She's excited about designing the system to give people power and determination over their lives, while focusing on quality and relationships.
m. **Tom Rees** spent his life as a CEO and consultant within hospitals. He has a family member who has received services, and has participated as a member of a family therapy team. He now serves as the chairman of the board for the Northeastern Family Institute of Vermont, which provides services to children and youth to keep them out of institutional settings.
n. **Kate Reilly** is a Co-Director of case management at the Central Vermont Council on Aging. She has worked for over 10 years providing case management for people on Choices for Care. She is both hopeful and concerned about ensuring there will be consistency in case management standards, as well as remaining focused on client direction.
o. **Christopher Rotsettis** is a member of the Department of Mental Health Program Standing Committee for Adult Health and is a junior at Northern Vermont University. He wants to ensure these changes in services do not result in a loss of quality.
p. **Cinn Smith** is from Rutland County and brings a family member perspective as the parent of a son who received services. Her family was one of the first to use self and family management, which opened many choices. She is worried about lack of choice in Vermont. Cinn works in independent service coordination for a small number of families. She wants people to experience the joys in life everyone does, regardless of labels.
q. **Nicole Villemaire** is a self-advocate with Green Mountain Self Advocates and a peer professional through the Howard Center. She is also on the

autism spectrum and receives services through Howard. She was worried about the changes that would come with Conflict-Free Case Management but also felt it will be helpful to those receiving services.

r. **Deborah Wesley** is the CEO of Addison County Home Health and Hospice. She is most excited for the opportunity for change. As Vermont is a rural state facing a healthcare crisis, she has concerns about making changes with a limited workforce without compromising care.
s. **Susan Yuan** is the mother of an adult son who receives services from Upper Valley Services. Susan also is on the Upper Valley Board and was selected to represent the State Standing Committee on Developmental Services. Her biggest worry is for her son's quality of life and relationships.

t. **The Steering Committee** introduced themselves:
    i. Dylan Frazer, Deputy Director of Medicaid Policy, Department of Vermont Health Access
    ii. Wendy Trafton, Deputy Director of Health Care Reform, Agency of Human Services
    iii. Conor O'Dea, HCBS Policy Advisor, Department of Vermont Health Access
    iv. Tracy O'Connell, Finance Director, Agency of Human Services
    v. Fran Hodgins, Administrative Services Director, Agency of Human Services
    vi. Bard Hill, Principal Assistant and Senior Policy Advisor, Department of Disabilities, Aging, and Independent Living
    vii. Angela McMann, Aging and Disabilities Program manager, Department of Disabilities, Aging, and Independent Living
    viii. Jeffrey Nunemaker, Developmental Disabilities Services Deputy Director, Department of Disabilities, Aging, and Independent Living
    ix. Alexandra Nerenberg, Case Management Director, Department of Mental Health
    x. Dana Robson, Children and Families Operations Chief, Department of Mental Health

xi. Eva Dayon, Assistant Director of Quality Management, Department of Mental Health

3. Background: Sharon Lewis, HMA

a. Medicaid HCBS Case Management

i. Case management, also called service coordination, is an important part of HCBS. Case management helps people access the services and supports they needs that people need to be able to reach their goals and live full and healthy lives. Case management helps make sure there is consistency, fairness and equity, and quality in HCBS.

ii. Case management has to balance both supporting people who receive services, and supporting the system. Conflicts sometimes come up when trying to do both.

iii. Sharon shares a chart that shows case management functions for service recipients and HCBS systems. These steps are inter-connected, and sometimes take place in different order, depending on the person and their situation.

1. When people are applying for services and supports, case management entities need to make sure that there is equity, fairness, and opportunity. Biases cannot get in the way of an equal system.
2. From a Federal perspective, Medicaid is clear that the decision around who is determining eligibility is important. This role must be implemented by the State or delegated to another government entity.
3. By using standardized and consistent processes for needs assessments, the case management entity can help make sure the system is equitable and fair.
4. Case managers are central to planning supports focused on the person. Meeting both people's preferences and their needs are important and need to be balanced. Person-centered planning should be culturally responsive. It should honor the person and their family and meet them where they are.

5. It is important people are linked to services that they will benefit from. They should be given all available options. People should not be steered towards a particular organization.
6. An important part of case management is helping people access services aligned with their needs. It is important to create a plan that will be approved and have enough resources available. Case management makes sure this is done in a fair way.
7. Case management should make sure that services delivered to a person are working for them, and match what was planned. Case management has an important role in overseeing services and maintaining quality.
8. It is important to note that one person isn't necessarily performing all of these activities. This list represents the functions within case management.

iv. In Medicaid, case management is not the direct delivery of services. Case managers cannot be back up direct care staff. They cannot deliver services covered in another Medicaid service, like transportation.

v. There are five Home and Community-Based Services programs under the Vermont Global Waiver:
    1. Choices for Care
    2. Developmental Disabilities Services
    3. Brain Injury Program
    4. Community Rehabilitation and Treatment
    5. Intensive Home and Community-Based Services (formerly Enhanced Family Treatment)

b. Conflict of Interest: **Sharon Lewis, HMA**
    i. Our goal is to figure out how to design a system for case management that reduces or gets rid of conflict.
    ii. The Medicaid Home and Community-Based Services Conflict-of-Interest rules that Vermont has to follow are at 42 CFR § 441.730(b)
    iii. Explaining the rules Vermont will need to follow:
        1. Organizations can't be service providers and case managers for the same person.
            a. Examples of direct services are personal care, therapies, counseling, or employment services. Direct services providers are the people who work directly with the person receiving support to deliver the service.
            b. There may be exceptions in parts of a state with no other options. This is rare and the state will have to get permission from CMS to do this with a lot of protections for people served.
        2. Eligibility, needs assessments, and person-centered planning should be done separately from service delivery.
            a. Financial and functional/medical eligibility is always the responsibility of the state, although some aspects of the process can be delegated, the state always makes the final decision.
            b. Needs assessments are completed or reviewed at least once per year or more often when things change. People have tried to make formal assessments as consistent and standardized as possible, to try to be fair and equitable. There should be a reason behind why each persons' services look the way they do – based upon an assessment of their needs as well as their preferences. The needs assessment must be done by someone who is not delivering services.
            c. The development of a person-centered plan where services are selected, providers are chosen,

and a plan of action is created needs to be done by someone who is neutral. The plan should be in the best interest of the person, not the people delivering services. Everything happening in the plan must be about the person.

3. CMS is clear that people performing eligibility, needs assessment, and person-centered planning can't have relationships with the service delivery industry.
    a. The people performing these functions cannot be family members or a paid caregiver.
    b. They may not have legal power to make financial or health decisions for the person receiving services.
    c. They cannot be the person who is financially responsible for the person receiving services.
    d. They cannot be a rep payee for the person receiving services.
    e. They cannot have financial stake in the organizations who profit from the services being provided to the person they make decisions for.

iv. We will need to find ways to address organizations providing services and case management.
    1. This will be a challenge in Vermont due to the way the system is built. What we design must follow federal rules and serve the people of Vermont.

v. Examples of conflict-of-interest problems:
    1. People may be steered towards certain services or settings, and sometimes not even on purpose. The case manager's role is to present all choices and support an informed decision.
    2. In working in an organization delivering services and case management, there is unseen bias or steering that can happen.
    3. There may be incentives or reasons people may receive higher or lower services based on the actions of that case manager.

4. Conflict occurs when the oversight happens within the same organization. It is hard for people to oversee people in their own organization.
5. Defining quality can also be hard. A service recipient should be able to provide feedback on whether or not their services are quality. The person receiving services should be able to say if services improve their life, health, and safety. We also have to measure some things that are not subjective.

c. Where do Committee members see the areas for conflict?
    i. Deborah explains that in a Home Health Agency (HHA), she has different divisions. Sometimes, they provide services to CFC clients under the home care division, separate from the CFC. Will the Home Health Agency be able to provide case management services to a person getting in-home skilled nursing or therapies under Medicare, Medicaid or another payer?
        1. After some dialogue and debate, it is decided that the specifics of this question related to HHAs requires further attention and understanding.
    ii. Dar asks in the chat: So you're saying the case manager is a separate person from direct care- a physical therapist can't do case management?
        1. This was confirmed. These are two distinct roles when we are talking about HCBS case management and direct services.
    iii. Kirsten provides an example within developmental disability services. A lot of services are delivered by a single entity in this structure. Kirsten shared an example of the case manager authorizing borrowing against someone's future social security payments in order to cover expenses for that person. Even if done with the best intention, it is still a conflict.
d. There are many reasons for Conflict-Free Case Management.
    i. Conflict-Free Case Management protects the rights of participants. It makes sure participants have someone in the system to support them, not the provider.

ii. Addressing conflict can support more choices. A person receiving services may have a great, trusting relationship with their case manager. If there is no difference between the case management agency and the service delivery, how can they know all options are offered?
iii. Conflict-Free Case Management also brings better oversight. We will have a clear understanding of what service providers are doing versus case managers. This will also lead to better quality oversight.
iv. Equity has been an important topic over the last few years, as people have gotten engaged around racial, cultural, and service equity. We must make sure we provide services to a wide range of people in Vermont. This needs to be done in a way that is equitable.

e. Questions/Thoughts
   i. Nicole asks in the chat: I would say person-centered planning for developmental disabilities and conflict around staff shortages and case managers after fill-in when no one is available to support clients.
      1. Sharon believes this will be an important challenge in some parts of the system. During COVID, states had flexibility to allow case managers to deliver some services, but this is not an ongoing solution. Case managers should not be used as a backup for workforce shortages. How do we make sure that there are backup systems that don't require a case manager to show up and deliver direct care?
   ii. Max believes it is important that case managers and service coordinators are engaged in discussions about how people deal with the societal atrocities and oppression happening today. Throughout the years he has received services, staff has not asked him about how he is doing as a person of color with a disability after certain events – for example, what happened with Tyre Nichols or other individuals killed by police. Max wants someone to feel like they are being cared about. People with intersecting identities need to feel valued for who they are. Racism and ableism are affecting a lot of people. Systemically, there should be

an expectation that staff are checking in to see how people are coping.

1. Sharon agrees. She says trauma-informed person-centered thinking and planning is really important. She says case managers need to know what has happened to people in their lives and understand how other events in broader society affect people.
2. Max says staff may encounter individuals who may be profiled by the police. They would know what to do if this was put into the plan.
3. Bill says in the chat: Max is right. There needs to be a real relationship between a service recipient and the case manager. Goes way beyond box-checking.

iii. Bill adds in the chat: This is sounding like case management is a little more antiseptic than what reality will require. A good case manager must really know the individual.

iv. Susan says in her experience, a case manager doesn't know the full picture until they've seen their clients "pulling one on them." Without experience, it's hypothetical. She likes when the case manager steps in and gets this experience.

v. Nick says that in home health, there are designated programs that need to be delivered by a home health agency. They must do Choices for Care. Choices for Care has pieces of case management and service delivery. He thinks there may be problems in the structure here.

1. As of now, Vermont has things structured in ways that may not work under federal rules. Untangling and making changes may need to happen in regulations, laws, manuals, quality measures and payment. All of these might need to change depending on the final decisions.

vi. Nicole adds in chat: Case managers don't always contribute or agencies do not help understand to support people understand mental health or trauma, or use dialectal behavioral therapy to support people with disabilities.

1. Sharon says that there are a lot of challenges for people in the system and appreciated Nicole noting this.

4. Vermont's Efforts: **Dylan Frazer, DVHA**
    a. Goals for Vermont HCBS-COI
        i. Vermont is committed to their strong system that offers meaningful community integration, choice, and self-direction. They aim to promote health, wellness, and a better quality of life. They want to keep doing good things while complying with the new rules.
        ii. Vermont wants to minimize disruption to people and their families with these changes. The State wants to make changes with people in mind.
        iii. They want to avoid destabilizing the existing workforce. As of now, Vermont already has workforce shortages that have been brought up in the meeting. They want to remain aware of this.
        iv. The State wants to address issues clearly. Their goal is to be transparent through strong stakeholder engagement.
        v. Vermont wants to improve quality and equity as these changes are made. They also want to build on past and current work.
    b. Centers for Medicare & Medicaid Services Plan of Correction
        i. Vermont's plan of correction has not had final approval, but he doesn't think the plan will go through any other major changes.
        ii. The implementation of the plan of correction will happen in mid-2025.
    c. Other related initiatives
        i. The Agency of Human Services has other work in progress to make Home and Community-Based Services better. This includes work in quality improvement and critical incident reporting.
    d. Questions and Discussion
        i. Bill says that it would be helpful for Dylan to tell the Advisory Committee about decisions that have already been made that may change the Advisory Committee's work.
            1. Dylan addressed work on a certified community behavioral health center model. This plan wants to bring services together, while conflict-of-interest is working to separate services. This tension will be important to think about.
            2. Dylan acknowledged intent to be as transparent as possible.

5. Stakeholder Engagement: **Sharon Lewis, HMA**
    a. Stakeholder Engagement overall: It is important that the Advisory Committee and general public know about these decisions. The plan also features a robust communications strategy and plan for data gathering tools.
    b. The work will happen very fast. The original plan was to take 5 years to make changes, but CMS only gave the state 3 years.
    c. Communication: Email and Website
        i. The email list began on January 24th, 2023. People should add info@vermonthcbs.org in your email address book to avoid spam filters.
        ii. The website will be open in mid-March. The website will be a place to learn about Home and Community-Based Services Conflict-of-Interest.
    d. Advisory Committee
        1. Information about all future Advisory Committee meetings will be shared on the Conflict-of-Interest website and through emails.
    e. Provider Workforce Survey
        1. The goal of the survey is to learn more about the workforce and the structure of Vermont's providers. The survey will also help the team find missing information.
        2. Sharon shared a timeline for the provider survey. Results from this survey will be included in the April Assessment Report.
    f. Case Management Public Surveys
        i. Audience is people receiving services and families on one survey, and frontline staff on the other survey.
        ii. The goal of these surveys is to find out what case management functions are done by different people.
        iii. **Committee Action item:** The Advisory Committee needs to give the team their thoughts on these two surveys. The committee should share ideas on parts that are unclear. They should also look for things that are incorrect. This review will be done electronically. Members will be sent information about survey feedback with a due date and directions.

g. Journey Mapping: **Boyd Brown, HMA**
    i. Journey Mapping will help us to learn about how people experience case management. This will be done with five groups, one for each program. Each group will have 3-5 people per 90-minute meeting.
h. **Committee Action item:** Outreach ideas to find people to participate in journey mapping will be needed. Next week, an email will be sent out including journey mapping registration. We are looking for 15-25 people.

6. Wrap-Up and Next Steps
    a. Interested stakeholders can sign up for the Home and Community-Based Services Conflict of Interest email list.
    b. Advisory Committee members should email lpreston@healthmanagement.com with requests for accommodation.
    c. Pre-meetings are open to Committee members before Advisory meetings. If members have any questions or needs, please email Liz Preston (lpreston@healthmanagement.com) or Sam Di Paola (sdipaola@healthmanagement.com).
    d. Our next meeting will be **Tuesday, March 21st from 2:00-4:00 pm**.
    e. In response to a question in the chat, it was noted that Advisory members were chosen through an open public process where people could apply. A wide range of perspectives across the five programs were encouraged. AHS staff selected the membership.
    f. There was a question in the chat about how members of the public can participate. This will be addressed for the next meeting.

Meeting Materials

1. Vermont Advisory Committee Meeting PowerPoint
2. CMS Vermont Corrective Action Plan
3. VT-HCBS-COI Advisory Meeting Agenda