

Vermont 1115 Waiver Demonstration
Choices for Care
Quarterly Report April 2006 – June 2006
Revised

Summary:

The third quarter of the first year of implementation of Choices for Care consisted of activities which continued to fine tune the program and continue work on the design and implementation of the Flexible Choices (Cash and Counseling) portion of the program, payment of spouses and PACE.

Third Quarter Events:

Developing effective communication among all of the providers continues to be a significant activity in refining Choices for Care. Improvements in the understanding of the new program operations are evidenced by the content of the monthly meetings of the Long Term Care Waiver teams staffed by the LTC Clinical Coordinators. These meetings have shifted to center on their original intent of ongoing discussion of participants and their well being, the resolution of programmatic challenges and the creative solutions to service delivery. They have moved out of the realm of discussing new waiver procedures and processes.

Monthly meetings with the major service providers have been ongoing. Provider groups consist of the Executive Directors of the Area Agencies on Aging, the Vermont Association of Supervisors Team (VAST) which is comprised of Area Agency on Aging Case Management Supervisors, the Home Health Agency Case Management Supervisors, the Vermont Association of Adult Day Services (VAADS), and the Home Care Council, comprised of the Executive Directors of the designated Home Health Agencies. Topics of concern raised in these meetings regarded the need for monthly face-to-face visits by case managers, billing concerns, timeliness of the financial determination of applicants, and follow through by providers on the completion of paper work on change of settings, level of care and terminations.

In response to these issues, staff confirmed the need for monthly face-to-face visits, establishing documentation standards when case managers were unsuccessful in gaining access to participants in their homes. Monthly meetings continued with Choices for Care staff, the Department for Children and Families/Economic Services Division (eligibility determination unit), OVHA (Medicaid Managed Care entity) and EDS (Medicaid claims processing entity). Changes were made in the claims processing system and the two statewide half-day sessions were held for provider billing staff in June (agenda attached). Communication was sent to all providers via email, regular mail and banner pages on the EDS site to stress the need for completion of change forms when a participant changes setting or terminates from the program. Outstanding challenges continue to be receiving notification of participant status by particular provider groups.

The delay in financial eligibility determinations continues to be addressed. A review of participant status was conducted by the DCF central office and DDAS information and data unit. A concerted effort was made by DCF to determine the accurate status of individuals pending financial approval. Follow-up was initiated at the local district level by DCF Eligibility Specialists. As a result, a 60 day closure procedure was created and instituted by DDAS staff. This process consists of developing a list of Choices for Care applicants who have not filed for their financial determination 60 days after the clinical determination has been made. This list is reviewed by the waiver teams, which includes local case managers, the LTCCC, Economic Services staff, nursing home staff, and other providers prior to a notice being sent to the individual. A determination of current status is made and appropriate action taken depending upon each individual's situation.

The Long Term Care Clinical Coordinators (LTCCC) continued to meet monthly with central office staff. During the third quarter, the LTCCC also met with all of the Long Term Care Ombudsmen to discuss how best to implement the new charge of the Ombudsman program to provide service to Home Based and ERC participants. A particular focus of the Ombudsman program will be to do outreach to participants who reside in the Shared Living option of the Choices for Care program. Shared Living is an unlicensed arrangement between the participant and the home provider who provides care. This will enable more individualized living arrangements for those individuals who need twenty-four hour support in order to avoid nursing home

placement. Additional training was given on HIPPA requirement and rules, SAMS (the data system for the Division) and Flexible Choices.

Flexible Choices, Vermont's Cash and Counseling Program, began to come together during this quarter. Contracts were finalized with our providers, internal procedures were developed, providers and potential participants were identified, contacted and informed about the start of this option. The outcome of this quarter's activities is that DDAS is ready to begin enrollment for this option early in the next quarter.

The contract with Transition II to serve in the role of consultant to participants in Flexible Choices was signed during the third quarter. Training for the consultant entity was completed over several sessions. Training consisted of: an overview of long term care Medicaid; determining consumer needs through use of the Independent Living Assessment tool; allowance and budget development; individual goal setting; and individual monitoring and quality issues.

The Fiscal Intermediary Service Organization contract was completed and signed with ARIS Solutions. In preparation for the start of the Flexible Choices option, the Fiscal ISO developed procedures for processing requests for goods, services and cash, developed payroll and non-payroll request forms, and drafted a report format which will be sent to participants on a monthly basis to monitor their expenditures.

Flexible Choices staff, working closely with other Choices for Care staff, drafted procedures for this option. A draft document was distributed to our advisory group, other state staff, the consultant and fiscal ISO as well as CMS for review and comment. These procedures included an Employer's Handbook, specifically for Flexible Choices. Subsequent to developing these procedures, forms were drafted to assist in making these procedures operational.

The Flexible Choices Project Director visited 13 of the 14 state waiver teams during this quarter. In those meetings, details on this option were presented and feedback solicited from providers. These meetings produced many excellent suggestions for improvement. In April, consumers received a mailing informing them that Flexible Choices would soon be available. This mailing

briefly described the option and solicited feedback and questions. On the basis of this mailing and feedback from consumers and providers, the target group was refined to those individuals who are currently consumer or surrogate directing their personal care services in Choices for Care. Staff developed a mailing targeted to this group scheduled for when this option is ready to begin enrollment.

Staff developed a quality plan late in the previous quarter. During this quarter, staff from the Cash and Counseling National Program Office and the Scripps Gerontology Institute reviewed the plan. The Flexible Choices and Quality Management Project Director jointly submitted the plan for presentation at the National American Evaluation Association Convention and the proposal was accepted. Unfortunately, out-of-state travel limits will prevent staff from presenting at this conference.

The Flexible Choices Project Director and the Individual Services Unit Director attended a seminar on strategic communications sponsored by The Robert Wood Johnson Foundation as part of the Cash and Counseling Grant. The Project Director also attended the national Cash and Counseling Annual Retreat in May. Staff from the Cash and Counseling National Program Office performed a site visit in June and confirmed their satisfaction with Vermont's progress. Finally, Department staff is actively involved in the development of a Consumer Directed Module – a web-based initiative that is designed to facilitate communication among the various parties involved in consumer-directed options (i.e., the consumer, the fiscal intermediary, the consultant and the state).

PACE development and implementation continues with weekly meetings between the PACE state staff, Individual Support Unit staff, EDS, other state departments and the PACE provider.

The State submitted its PACE application to CMS on February 1, 2006. As a result, a list of questions has been received from CMS. The State and PACE is in the process of drafting a response. The PACE Center and the State are also heavily involved in preparing for the readiness review which is scheduled for October.

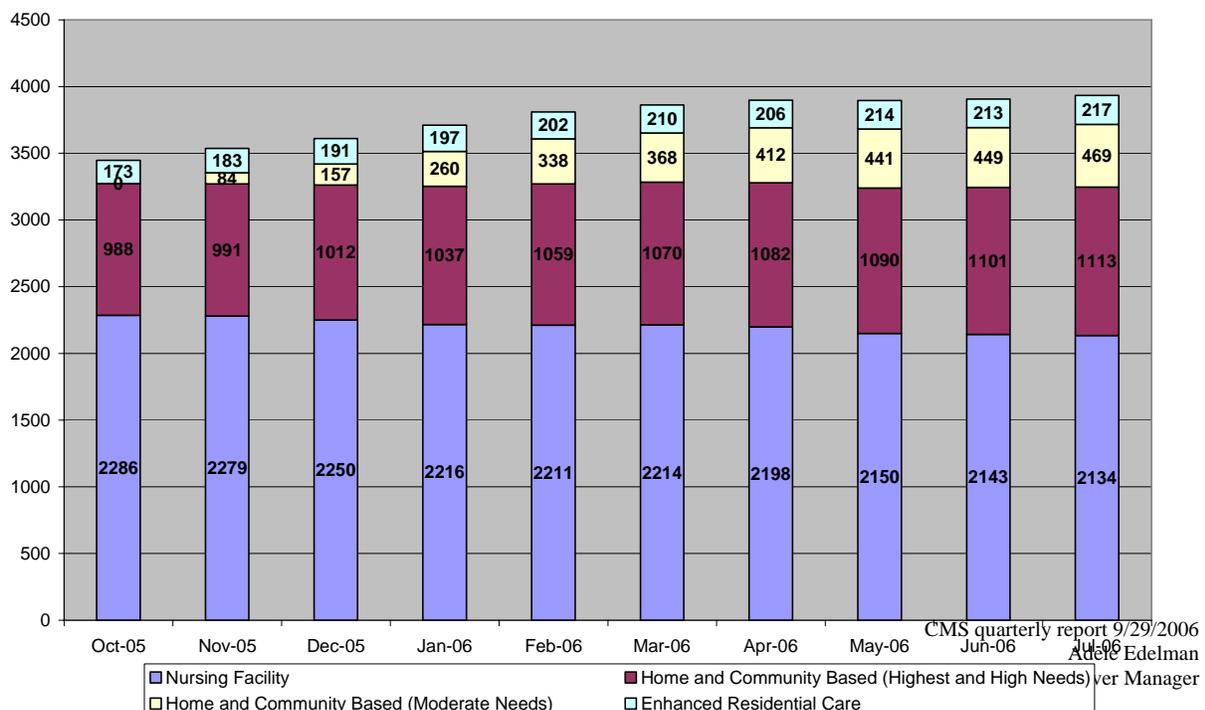
Weekly meetings were established to begin the dialogue and development of the proposal to pay spouses as caregivers. The committee included

representatives of the Choices for Care central office and district staff, consumers, case managers and other unit staff. A proposal was developed and has been sent to the DDAS Leadership Team for review and comment.

The integrity of Choices for Care data has improved as a result of new program operations put in place, the refinement of communication forms, follow up procedures and clean up efforts. However, data management continues to be an ongoing challenge. Efforts continue to be developed to assure reliability of data and adjustments designed to address this problem. The Information and Data Unit have worked continuously to redefine the data elements and explore alternative methods to assure consistency and eliminate system errors.

As noted previously, on October 1, 2005 all nursing home residents, community-based and enhanced residential care participants were migrated into the SAMS data base system. A total of 3,447 individuals were automatically enrolled in Choices for Care – 2,286 were nursing facility residents; 988 were home and community-based residents; and, 173 were enhanced residential care residents. As of June 30, 2006 there were 3,933 individuals enrolled – 2,134 nursing facility residents; 1,582 home and community-based individuals; and, 217 enhanced residential care residents - a net gain of 486 individuals in nine months.ⁱ This increase also includes the Moderate Needs Group.

**Choices for Care: Total Number of Enrolled Participants
October 2005 - July 2006**

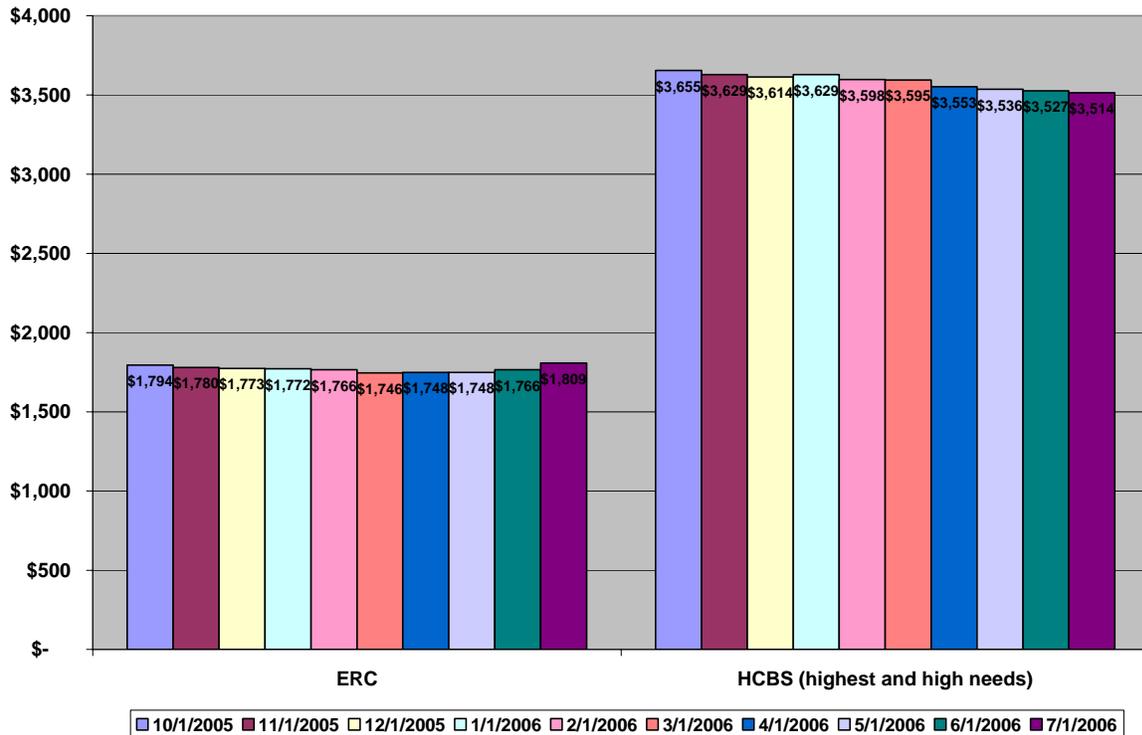


As of June 30, an additional 127 nursing facility residents, 90 home and community-based individuals and 14 enhanced residential care residents were found clinically eligible but were pending financial eligibility.ⁱⁱ The pending applications have been reduced by half as a direct result of efforts made to improve the eligibility process.

The waiting list for High Need individuals was 68 as of June 30, 2006.ⁱⁱⁱ Prior to Choices for Care, the home and community-based program had 260 individuals awaiting a “slot” to receive services. As the state’s fiscal year ended on June 30, 2006, we determined that there was sufficient funding to remove 11 people from the High Needs waiting list. It is anticipated that we will begin services for these individuals in the next quarter.

Average service plans continue to decrease during the second quarter. In October 2005 home-based plans averaged \$3,655 and ERC plans averaged \$1,794. By June 2006 the average home-based plan was \$3,514 and ERC plans had a slight increase to \$1,809.^{iv} This increase appears to be a result of the ERC option as a more readily accessible option for individual who previously received their care in a nursing facility.

**Choices for Care: Average Monthly Costs of Approved Plans of Care
October, 2005 - July, 2006**



Nursing facility paid Medicaid days were reduced from 70,037 in September to 65,968 in December and further reduced to 59,057 as of the end of the second quarter. ^v

Spending data at this time gives a fluctuating picture of expenditures during this quarter. Nursing home expenditures are high due to recoupment and repayment issues. Adjusted claim data indicate the following expenditures: ^{vi}

Paid claims	October '05	December '05	March '06
Home based, including moderate	\$2,261,219	\$3,344,840	\$2,804,888
ERC	\$248,600	\$292,522	\$281,557
Nursing Home	\$8,619,253	\$8,637,174	\$12,997,034

Progress of Quality Assurance Activities:

As part of the Real Choices System Change QA/QI Grant, the Quality Management Committee met monthly during this quarter to continue the

development of potential desired outcomes of services. During this period, Green Mountain Self-Advocates was contracted to seek feedback on a draft set of outcomes and indicators from consumers and families across the state.

A departmental team was formed and charged with the task of developing a policy for a Division-wide Critical Incident Reporting Policy and a Critical Incident Reporting Management System. This group continues to meet.

The Quality Management Unit conducted and completed the first CFC on-site provider review. Changes in the review documents and process are being incorporated into ongoing reviews in order to improve the effectiveness of the reviews. Reviews are extensive in nature, soliciting input from participants, their family members, staff of agencies and agency management personnel. Document reviews are also essential in the discovery process. Reports discuss findings, offer technical assistance, recommendations, and requirements noted in corrective action plans. The quality Management Unit has scheduled all CFC providers for reviews through September, 2007.

Continued training for the Quality Management Unit staff is a significant activity in the initial program as this unit is newly formed and the interim quality management process is also new. Training has centered on implementation methodologies described in *the Choices for Care Onsite-Review Protocol: Guide for Providers and Reviewers*. The quality Management Unit also continues to meet with providers to discuss *Plan* and *Protocol*.

Summary of Notable Accomplishments:

- Two statewide half-day sessions were conducted to address billing systems and to train provider billing staff in billing procedures and resolution of denied claims. Presentations were made to a wide range of groups. A copy of the most recent power point is attached.
- Initiation of the Flexible Choices option was put into place.
- PACE Center and state staff preparing for final readiness review.
- Reduction in pending applications was a direct result of concerted efforts of DCF/EDS and DDAS staff in problem resolution.

- Implementation of the Interim Quality Assurance Plan.
- Continued reduction in utilization of nursing facilities.

ⁱ Active participants by setting & loc,706

ⁱⁱ Received pending application.706

ⁱⁱⁱ High needs wait list by county.706.

^{iv} Approved poc costs erc & hcbs.706

^v 5/3/06Act160-06.xlwjim's monthly

^{vi} 5/3/06Act160-06.xlwjim's monthly