

# Vermont 1115 Waiver Demonstration Choices for Care Year II Quarterly Report October 2006 – December 2006

## INTRODUCTION

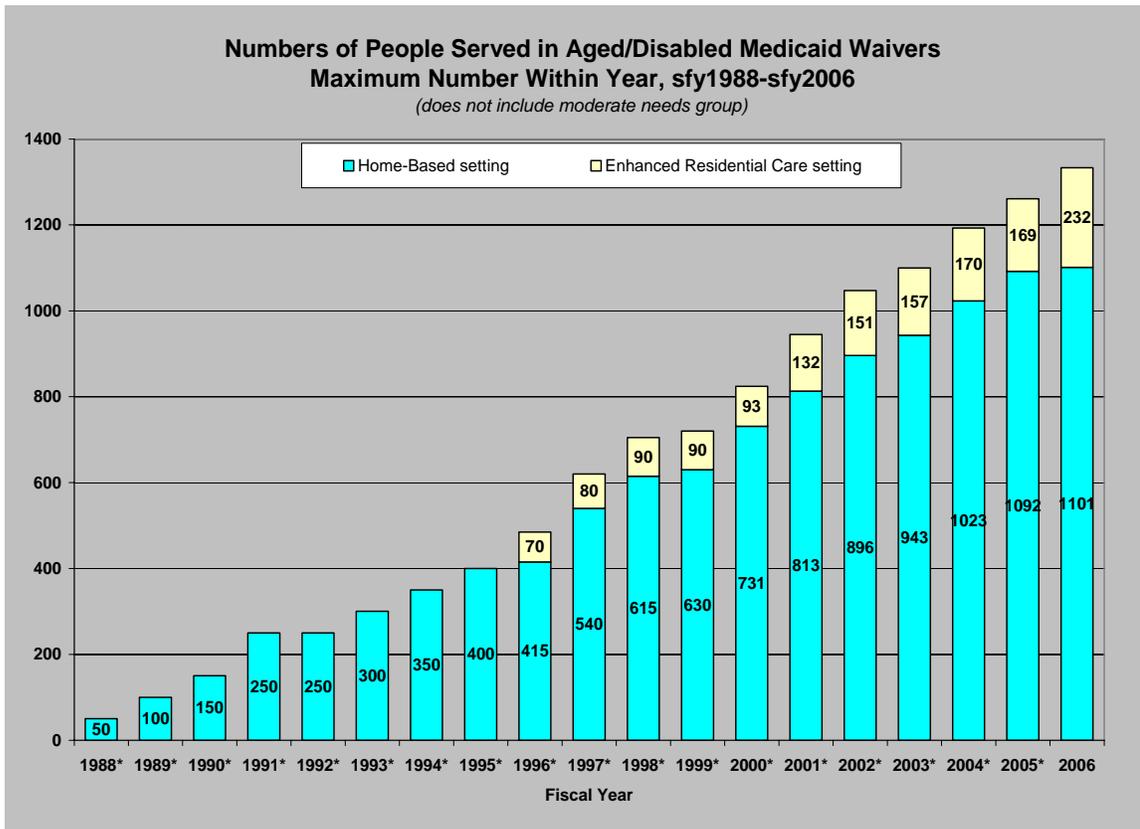
This period marks the first quarter of the second year of operation of the Choices for Care waiver. The Choices for Care program has been the center of interest throughout the country as evidenced by the numerous incidents of press coverage and phone inquiries from other states received during the quarter.

- *Wall Street Journal* article, October 10, 2006
- *Brattleboro Reformer* article, October 16, 2006
- *Rutland Herald* article, November 2, 2006
- *Times Argus* article, November 2, 2006
- *The Caledonia Record*, November 6, 2006
- *AARP Bulletin*, December, 2006
- *Recipient of the Council of State Governments Silver Society Award*, November 2006

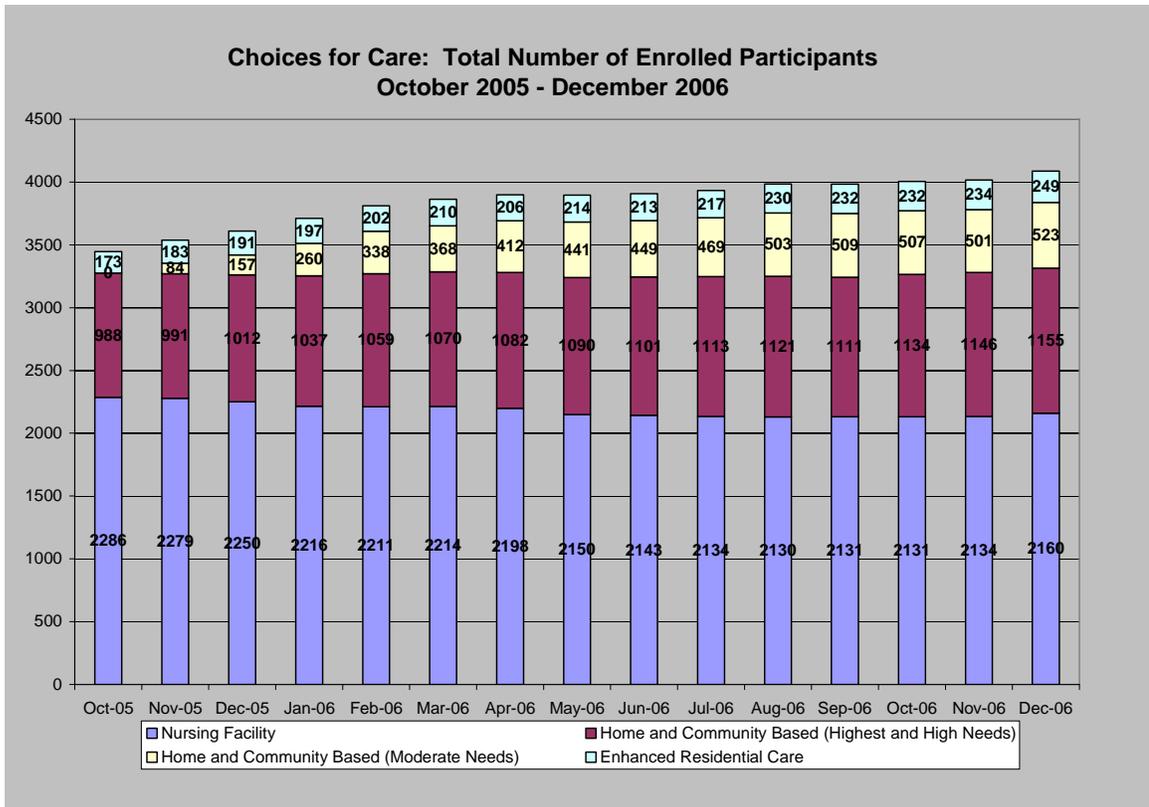
A review of where we have been and where we are going follows. This year the quarterly reports will focus on the data and track the program growth and trends to illustrate the program's influence on increasing home and community-based services and future directions.

## NURSING FACILITY, ENHANCED RESIDENTIAL CARE AND HOME AND COMMUNITY-BASED SERVICES

The graph below illustrates the controlled growth in home and community-based services in Vermont prior to the implementation of Choices for Care. This growth was fairly steady but limited by funding. During this time period all eligible Vermonters were entitled to nursing home care, while some people who applied for home and community-based care were placed on waiting lists. As expected, we continue to see a decline in people receiving long term care services in a nursing facility and a steady increase in those receiving services in the home and community-based service system.

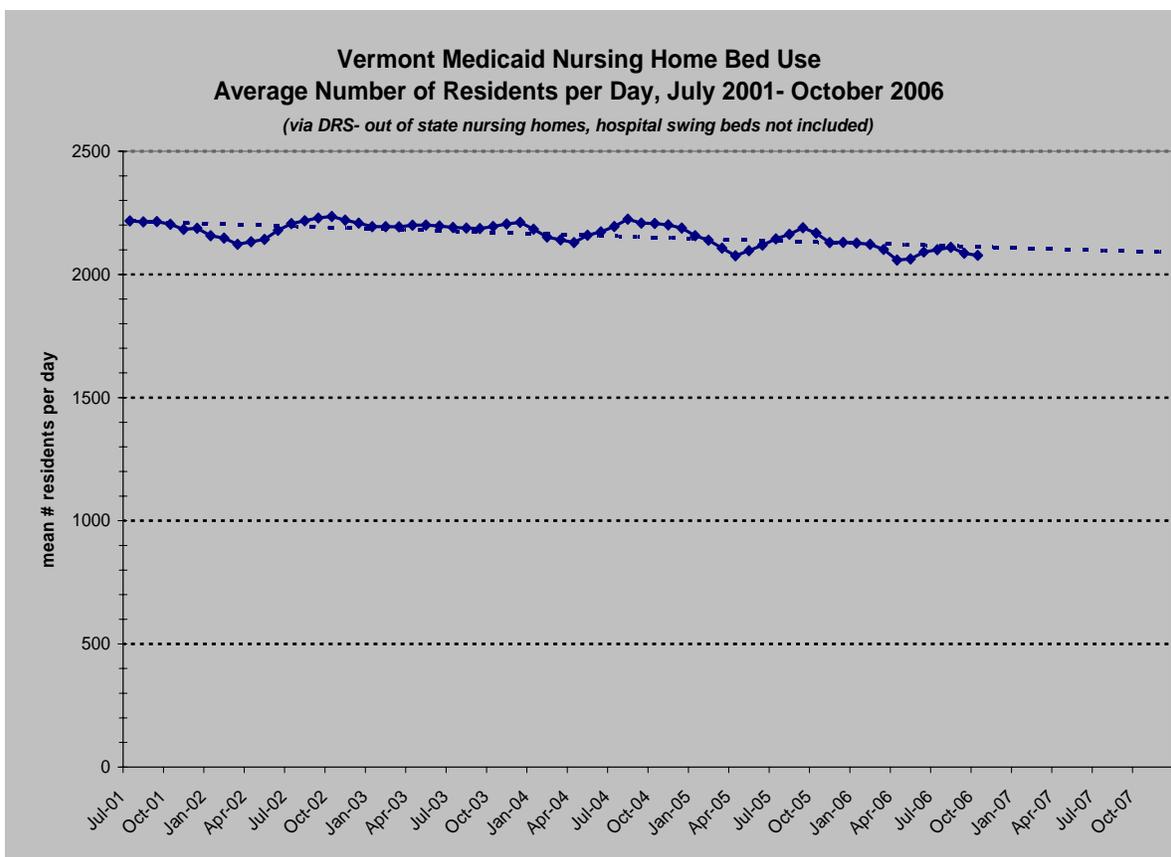


The following graph shows the number of participants enrolled in each Choices for Care setting since inception (October, 2005).

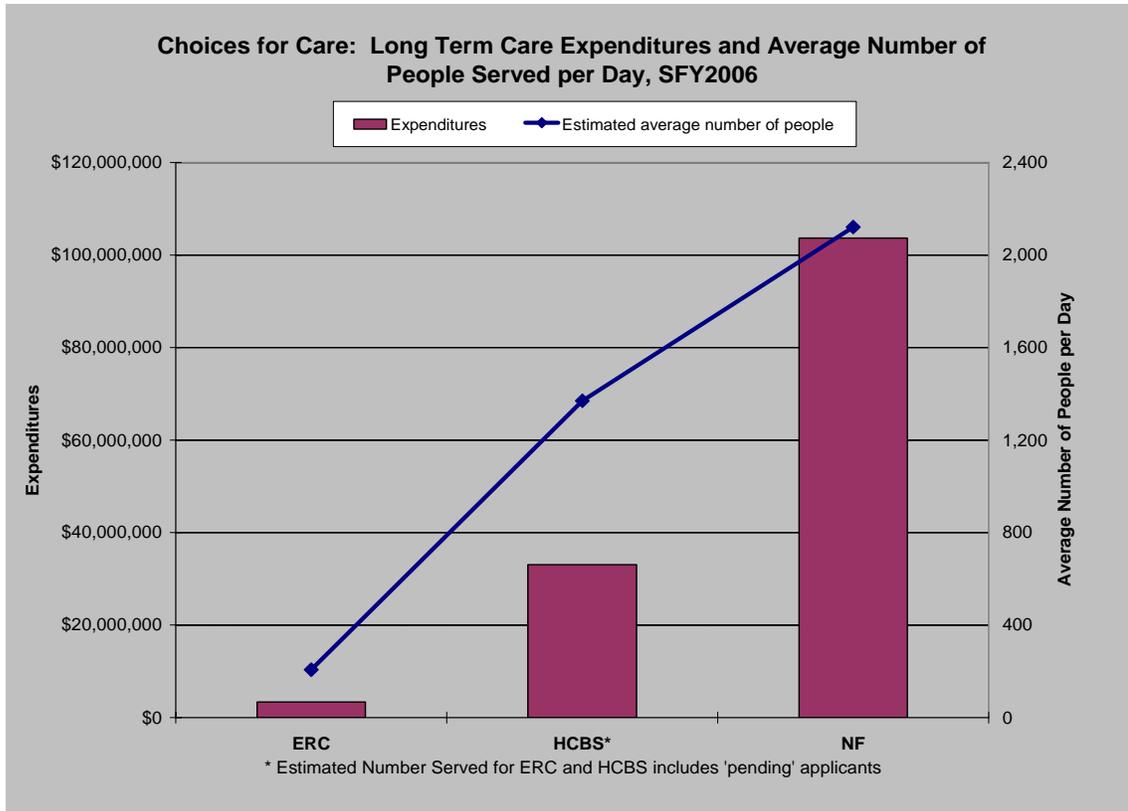


The number of people served in nursing homes has decreased, while the numbers of people served in the home and community-based and enhanced residential care settings have increased. Between October 2005 and December 2006 the following changes in services were noted:

- The number of people in nursing homes under Medicaid decreased by 126 (from 2,286 to 2,160).
- The number of people receiving home and community-based services (Highest/High Needs Groups) increased by 167 (from 988 to 1,155).
- The number of people served in enhanced residential care increased by 76 (from 173 to 249).
- The people accessing moderate needs services increased from 0 to 523.

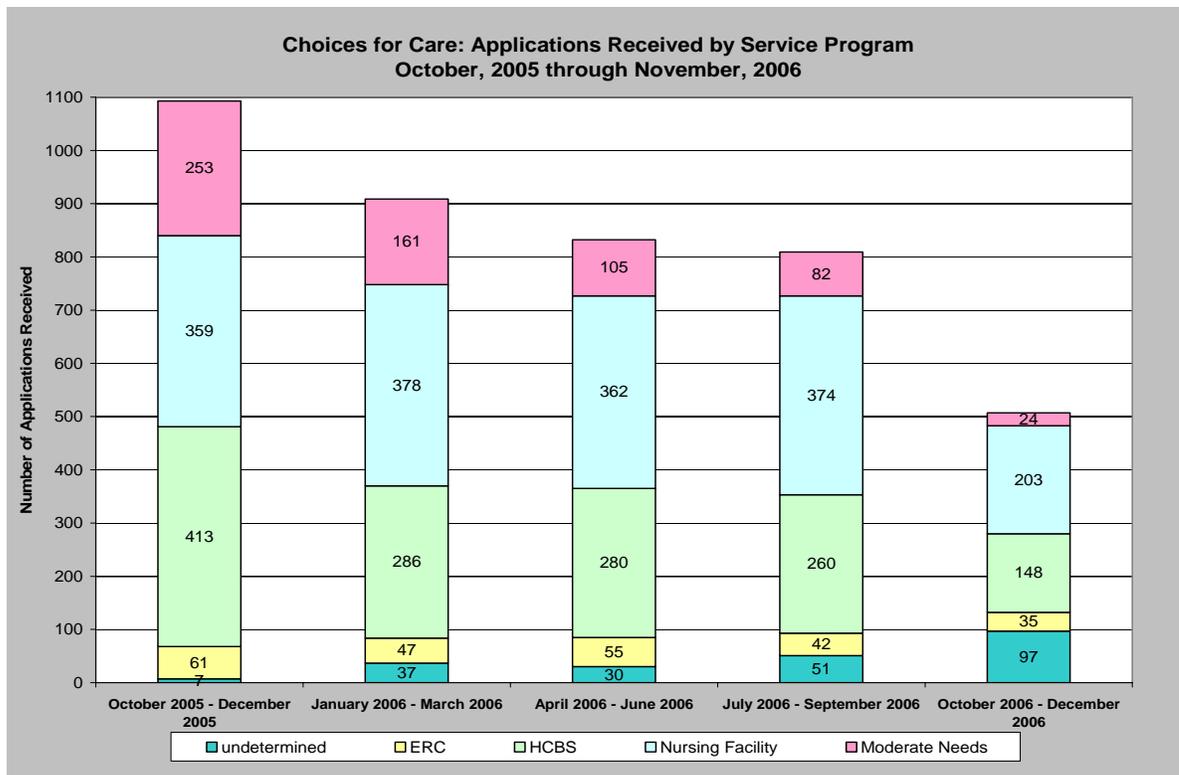


This above graph represents the number of nursing homes days with Medicaid as the primary payer each month, as reported by Vermont nursing homes to the Division of Rate Setting. Consistent with the previous Choices for Care data, this shows a consistent decrease in the use of nursing homes by Medicaid residents.



This graph below shows Medicaid long term care expenditures and estimated numbers of people served by setting in state fiscal year 2006.

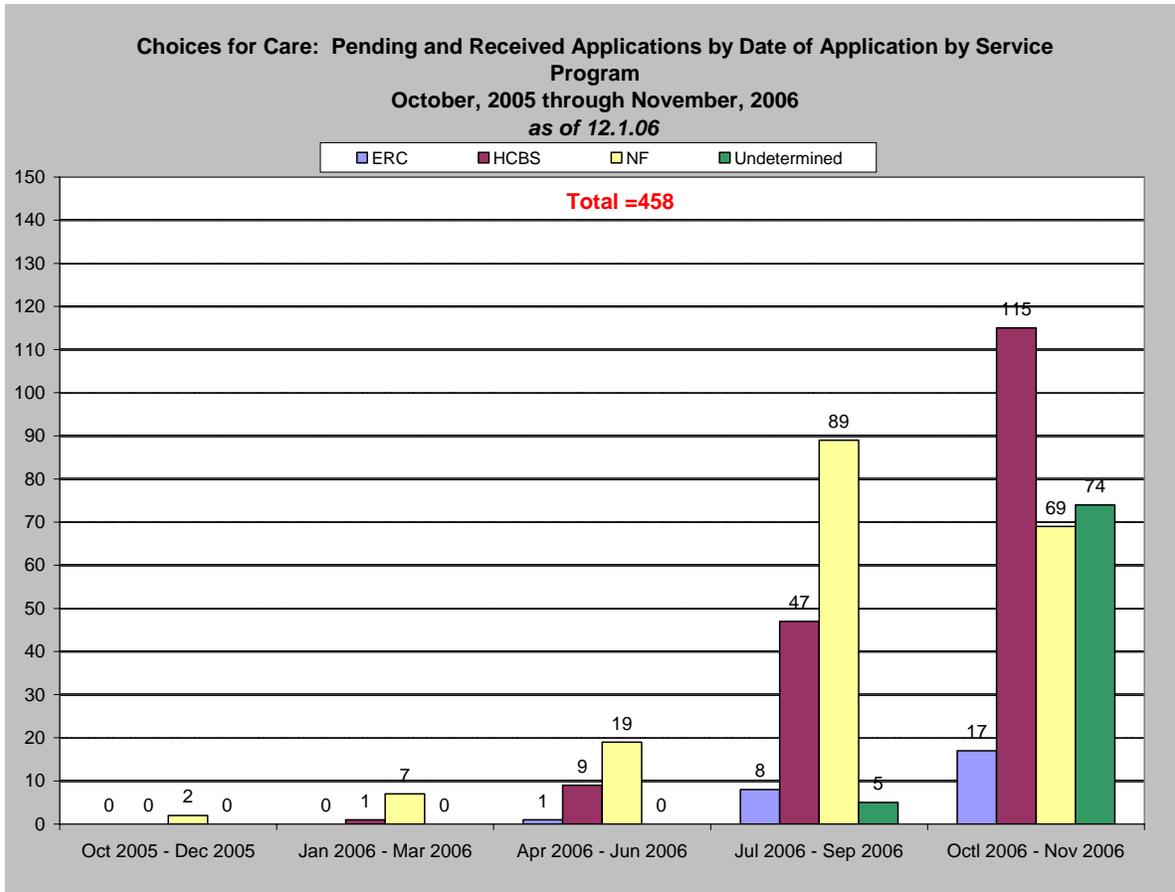
About 74% of the expenditures were in the nursing facility setting, while 24% were in the HCBS setting and 2% were in the ERC setting. In comparison, on an estimated average day, 57% of the people were served in the nursing facility setting, while 37% were in the HCBS setting and 6% were in the ERC setting. (Note: the estimated numbers of people served in the HCBS and ERC settings include 'pending' applicants, which increases these numbers by a modest percentage.)



DAIL received 505 Choices for Care applications in October 2005, significantly more than in any subsequent month. The pent-up demand represented by people on preexisting waiting lists for HCBS and ERC services (241 people in September 2005) contributed to this large number of applications.

While the monthly number of applications received after October 2005 has declined, most of this decline is due to a decrease in the number of applications for the Moderate Needs Group. DAIL/DDAS continues to receive an average of about 250 applications per month. Nearly half of the applications are for Nursing Facilities (including short-term and rehabilitation nursing home admissions under Medicaid.) About 35% of the applications are for Home and Community Based Services, and about 7% are for Enhanced residential care.

One of the goals of Choices for Care is to process individual applications in a timely manner. This graph shows the months in which pending applications were received.



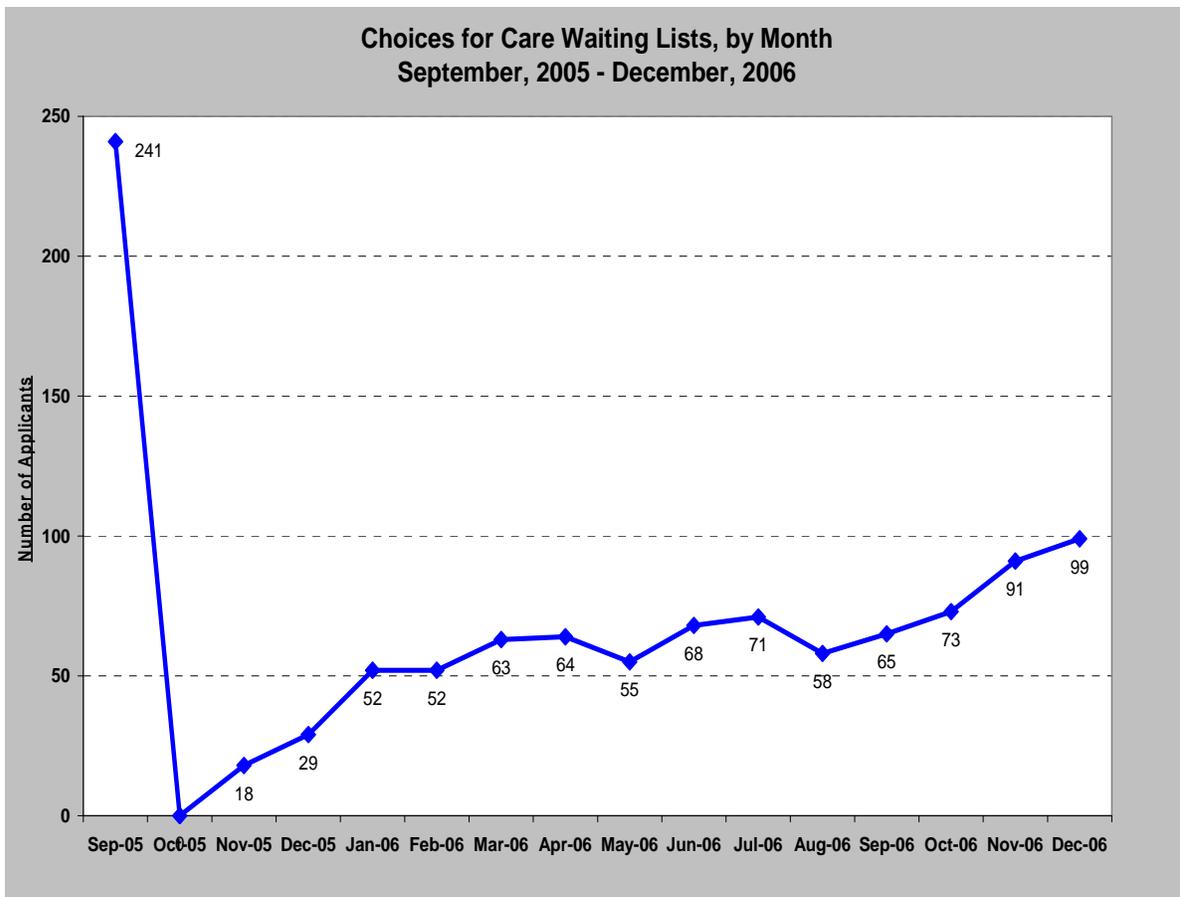
While many applications are fully processed within eight weeks, a small number remain pending for many months. DAIL data shows that 95% of the applications received before July 1 have been fully processed, 80% of those received before October 1, and about 40% of those received after October 1. Common causes for delays in determining Medicaid eligibility include:

1. Long-term care Medicaid applications are not submitted.
2. Long-term care Medicaid applications are delayed or incomplete.
3. Some applicants under the age of 60 (those not already eligible for SSI) are required to undergo a Disability Determination process, which routinely requires several months.
4. Some applications lead to complicated asset searches and/or legal review by the Department for Children and Families (DCF).

Staff from DAIL and DCF continue to work together to find ways to process applications as quickly as possible.

Applications are pending in every Vermont County. Two counties with large populations (Chittenden and Washington) also have large numbers of pending applications, while two other counties with large populations (Rutland and Windsor) do not. Some counties with smaller populations have a relatively large number of pending applications (e.g. Orleans).

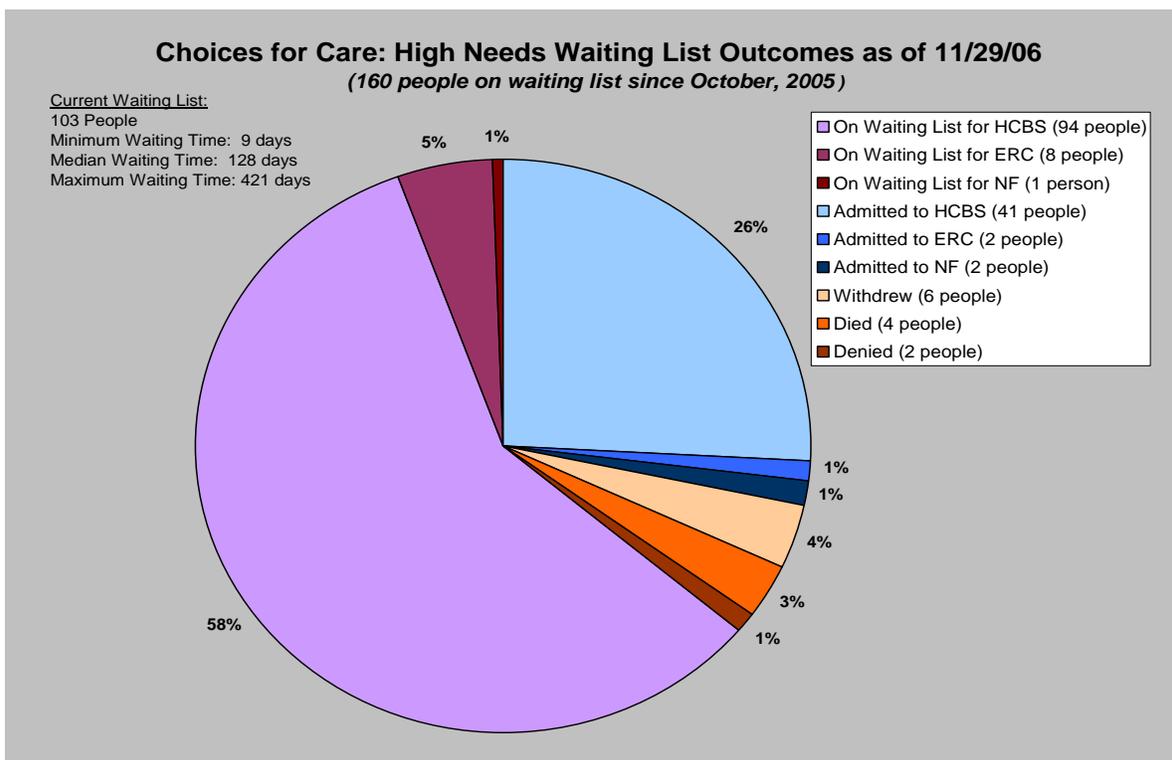
During this quarter, applicants who meet the High Needs Group eligibility criteria were placed on a waiting list. The number of people on this waiting list slowly increased over time. This was addressed in the second quarter of Year II.



Prior to the implementation of Choices for Care, access to home and community-based services and enhanced residential care were limited by available funds, and many applicants were routinely placed on waiting lists. The total number of people on waiting lists fell substantially when Choices for Care was implemented in October 2005, when all applicants who met Highest Needs Group eligibility criteria became entitled to services.

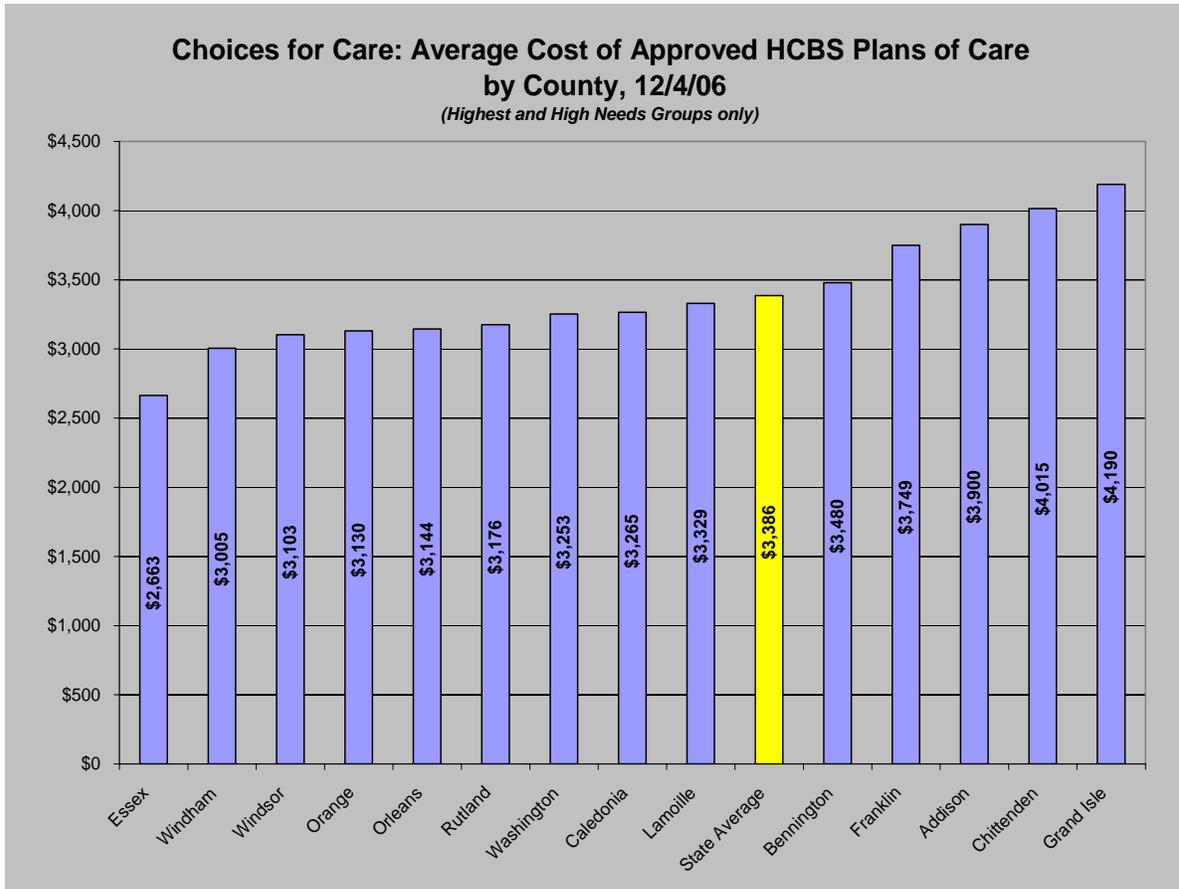
Some people from the waiting list have been admitted under special circumstances or because their needs increased so that they met the Highest Needs Group eligibility criteria. This includes 41 people admitted to home and community-based services, 2 people admitted to enhanced residential care, and 2 people admitted to nursing facilities.

Based on the availability of funds, 11 people from the High Needs Group waiting list were enrolled in Choices for Care during July 2006. Discussions have begun regarding the possibility of enrolling a second group of people from the waiting list. In December, a decision was made to take an additional 65 individuals off the waiting list. This movement will be evident once the applications have been processed.



This graph shows the outcomes for all applicants who have ever been on the Choices for Care Waiting List. Of all applicants, 65% remained on the waiting list as of December 1, 2006, while 28% had been enrolled in Choices for Care.

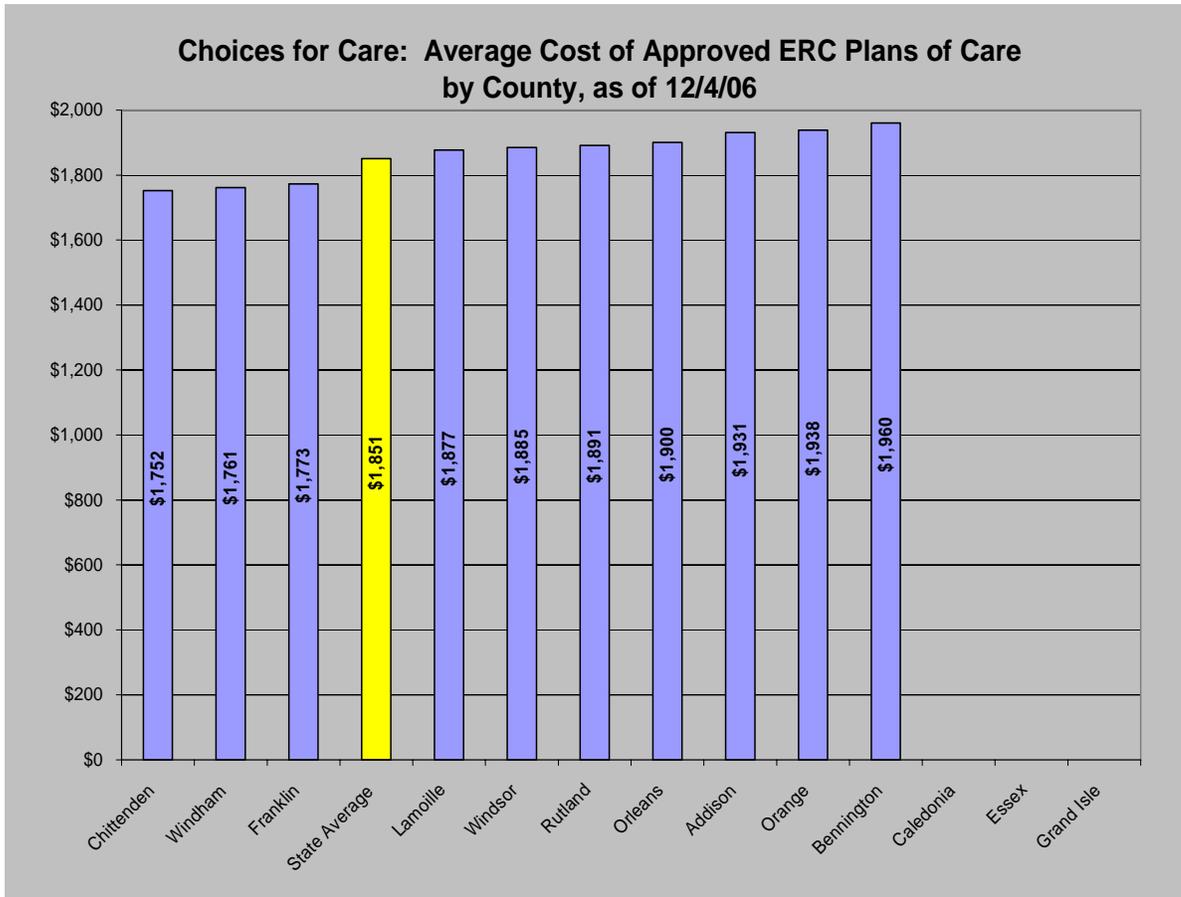
The average approved cost of HCBS Highest/High Needs Group Plans of Care was \$3,386. The average costs in three counties (Grand Isle, Chittenden, and Addison) were at least 10% above the state average. The average costs in two counties (Essex and Windham) were at least 10% below the state average.



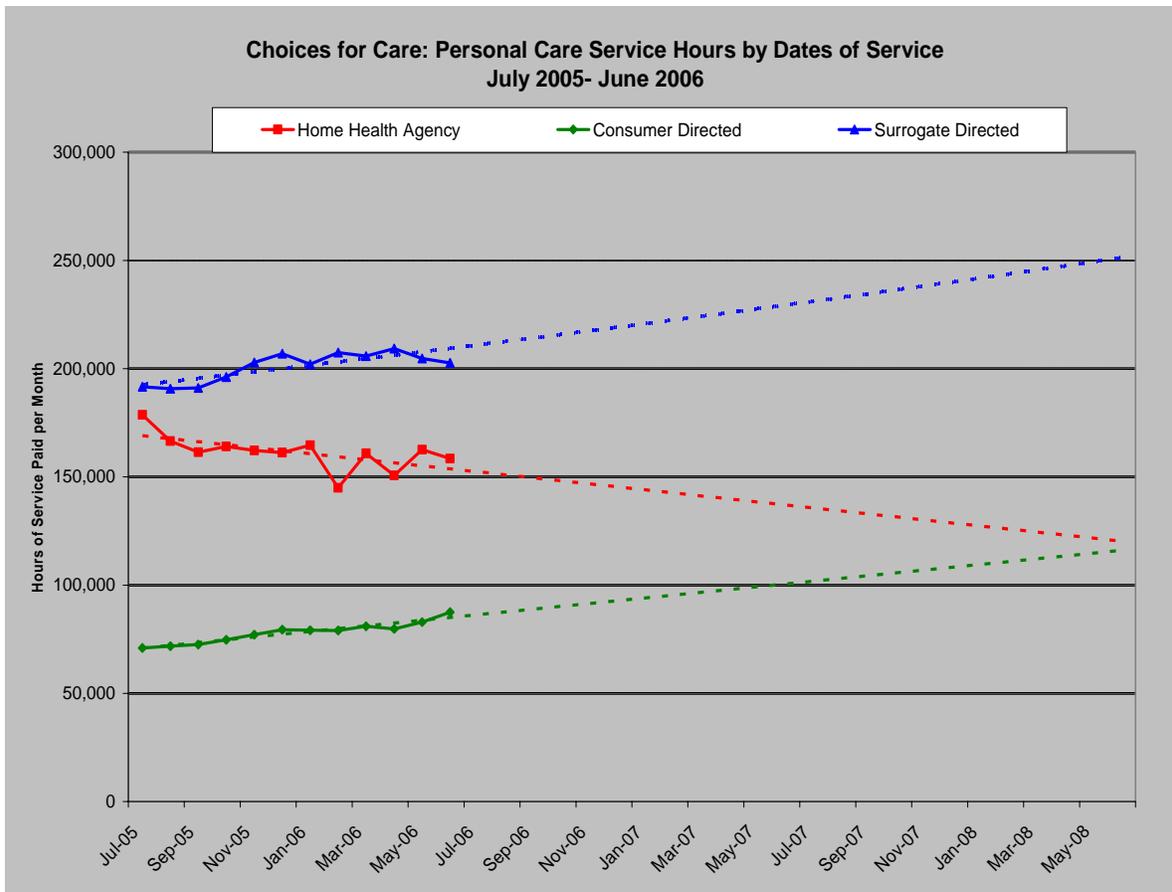
The available evidence suggests that several factors can contribute to higher costs of Choices for Care individual plans of care, including:

1. Greater use of Home Health Agency personal care services (as opposed to consumer- or surrogate-directed care), at a higher reimbursement rate.
2. Higher volumes of personal care services.
3. Greater use of adult day services.
4. Lower use of home health services (nursing and licensed nurse assistants) supported by Medicare or Medicaid state plan.

The average approved cost of ERC Highest/High Needs Group plans of care was \$1,861. This is about 45% less than the average approved cost of HCBS plans of care. The highest costs were found in Bennington, Orange, Addison, and Orleans counties. The lowest costs were found in Chittenden, Windham and Franklin counties.



The range of ERC plan of care costs is smaller because fewer factors contribute to the differences. ERC plans of care are based on three distinct daily reimbursement ‘tiers’, which directly reflect the functional and cognitive status of ERC participants but do not represent a specific number of hours of personal care. ERC plans of care do not include adult day services, which contributes to some higher HCBS plan of care costs.

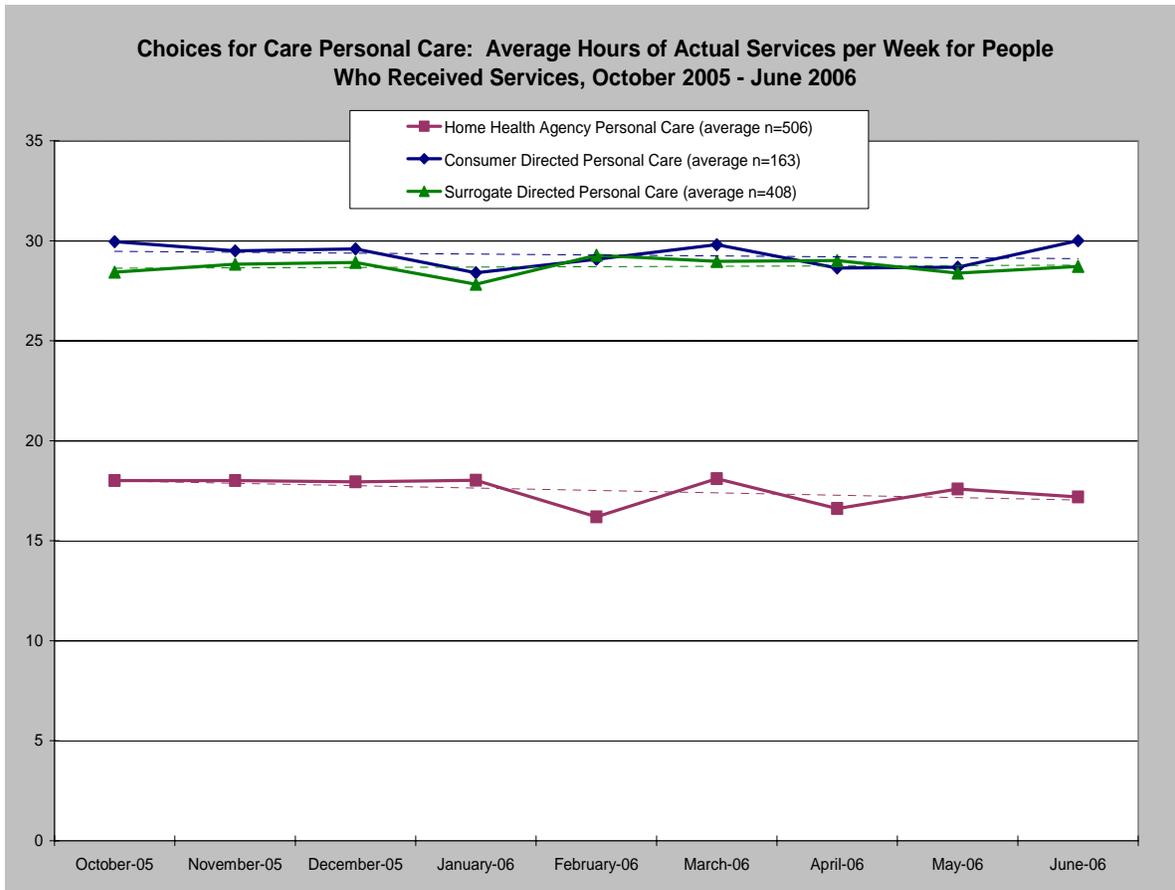


Note: consumer and surrogate directed data adjusted to reflect two pay periods in all months (reducing total actual number of hours in three months).

This graph shows trends in the three different Choices for Care personal care service options: home health agency, consumer-directed, and surrogate-directed.

Since the implementation of Choices for Care, continued expansion in the area of consumer- and surrogate-directed services has occurred. While this is consistent with the trends established prior to Choices for Care the percentage of personal care services provided via the consumer- and surrogate-directed option has grown to 65% of all personal care services provided. These personal care services cost about \$12 million less than the same services would have cost if provided through an agency at a higher reimbursement rate.

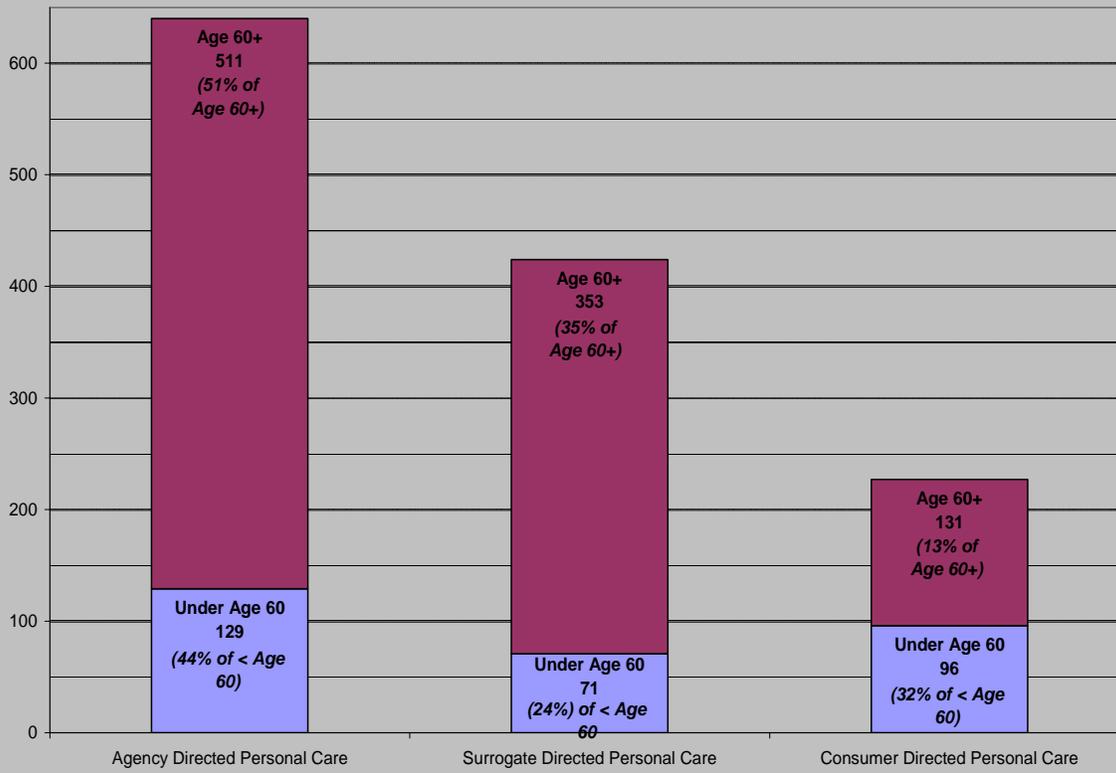
Possible implications include continued growth in a ‘non-traditional’ caregiver workforce, including family and friends; need for training and support of consumer and surrogate employers; need for training and support of consumer and surrogate directed caregivers; a continued ‘moderating’ influence of lower hourly reimbursement of consumer and surrogate directed services on the total cost of Choices for Care personal care services.



The above graph represents the actual number of hours of personal care services provided to Choices for Care participants, by management option. The data shows a slow decrease in the average number of hours of personal care services delivered per person across all service options.

However, the average number of hours provided to participants under the home health agency option is substantially less than the average number of hours provided under the consumer-directed and surrogate-directed options. Factors that appear to contribute to this difference are varied. One cause is that a higher percentage of caregivers in the consumer- and surrogate-directed options are friends and family members, making them more available to provide paid services on different days or at different times and locations. Additionally home health agencies may have more difficulty providing personal care staff at specific locations. People receiving home health personal care may be more likely to receive other similar services through the agency, including licensed nursing assistant services. These services are paid by Medicare or Medicaid state plan, but are not provided through Choices for Care.

**Choices for Care Personal Care Services: Age of Active Participants by Type of Service  
as of 11.28.06**



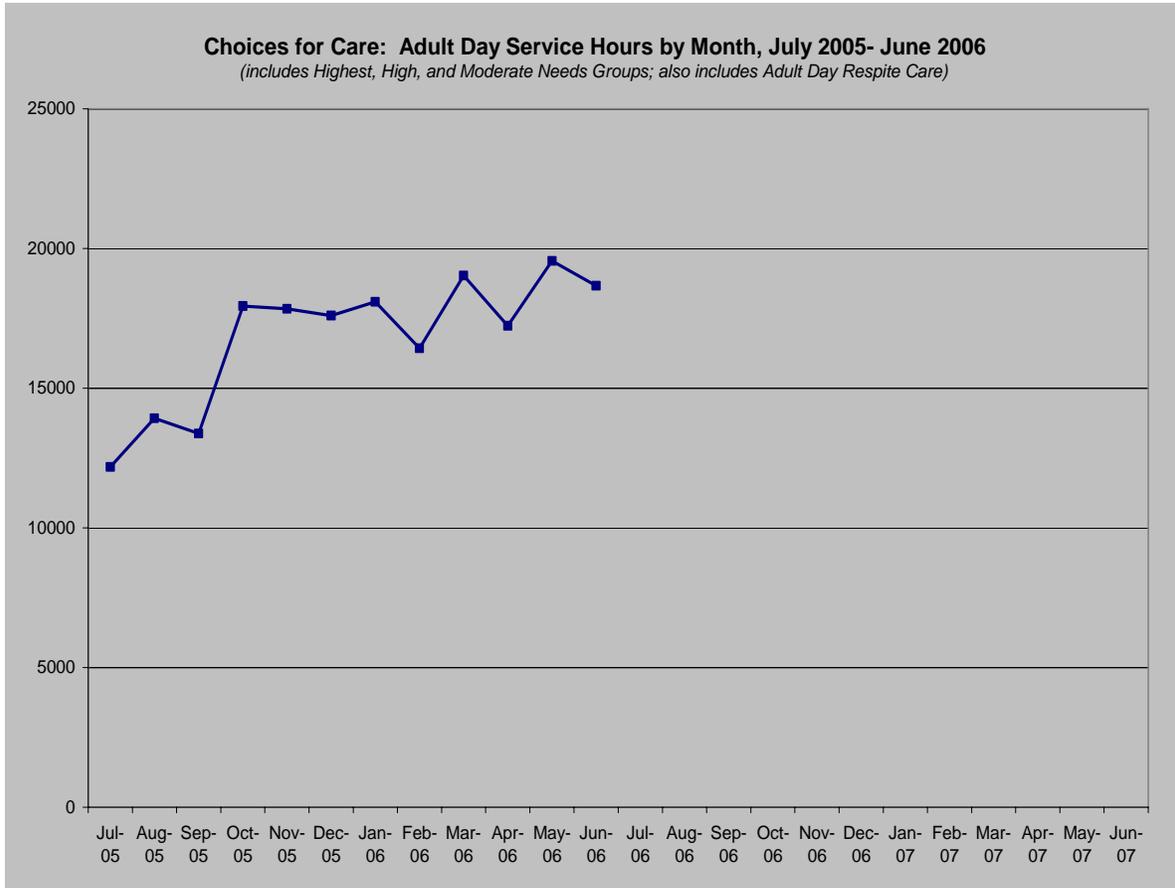
This chart illustrates the ages of people who chose the three different personal care service options. Conventional wisdom suggests that a much higher percentage of older people will choose agency services than younger persons. The percentage of people in each age group who use agency services is actually similar: 51% of people age 60 and over, and 44% of people under age 60.

There are more substantial differences between the two age groups in the other service options. Older people (35%) are more likely to use surrogate-directed services than younger people (24%). Younger people (32%) are more likely to use consumer-directed services than older people (13%).

The median age of people enrolled in the HCBS Highest/High Needs Groups is nearly 80. Due to the large number of older people enrolled in Choices for Care, older people outnumber younger people in every service option.

As of December 2006, the median ages of people enrolled in Choices for Care by setting were as follows: ERC, 87 years; Nursing Home, 85 years; Short Term Nursing Home, 80 years; HCBS Moderate Needs, 77 years; HCBS Highest/High Needs, 76 years.

This next graph shows increased use of adult day services supported by Medicaid long term care during the 2006 state fiscal year. The data includes services provided to the Moderate Needs Group, the new eligibility group that was created in Choices for Care in October 2005.



Between January 2006 and June 2006, adult day programs provided about 4,700 hours of service each month to people in the Moderate Needs Group. During this same time period, adult day programs provided an average of about 13,400 hours of service each month to people enrolled in the Highest and High Needs Groups.

**FLEXIBLE CHOICES**

While Flexible Choices, Vermont’s Cash and Counseling Program, began enrolling participants on July 24, 2006, enrollment has progressed very slowly so that the quarter ended with only 5 enrollees. Throughout their contacts with prospective participants, Transition II, the Flexible Choices consultant agency, has tracked why people who expressed interest in the program did not complete enrollment. From this information, it became clear that the primary barrier to enrollment was the perception that the discount rate – the 15% decrease

between the value of an individual's Choices for Care consumer- or surrogate-directed service plan and the amount of their Flexible Choices allowance – would lead to a significant loss of services. Whether the discount rate led to real losses, based on what consumers were actually spending, is not clear, but the perception of loss has proven very powerful. As a result, the quarter ended with the Department starting to consider eliminating the discount rate. Transition II, working from their consumer conversations, is confident that eliminating the discount will lead to a significant increase in enrollment. Initial analysis of expenditures suggests that eliminating the discount will not necessarily lead to a significant increase in expenditures, but that analysis is still underway.

As for the people actually using the option, contact with them and Transition II indicate that the move from the traditional program to the Flexible Choices option went smoothly. Monthly contacts between Transition II staff and consumers continue to indicate that participants are functioning well but are also able to identify issues that need to be resolved. Two of the participants, for example, have elected to hire case managers for limited number of hours as specific issues (a difficult hospital discharge being one) have arisen in their lives.

## **PACE**

PACE development and implementation continues with weekly meetings between the DAIL/DDAS, EDS, other state departments and the PACE provider.

The State and PACE continue to respond to questions from CMS staff. DAIL conducted the readiness review of the PACE site. PACE is anticipating offering services to participants in March, 2007.

## **QUALITY ASSURANCE**

As part of the Real Choice Systems Change QA/QI Grant, the Quality Management Committee met in October, November, and December. A first draft of the new Quality Management Plan was shared with consumers, families, service providers, and internally within the Division for feedback and input. Based on these activities, a second draft was developed and made available for broad public review.

The Quality Management Unit, working in collaboration with other DDAS staff, continued implementation of the Choices for Care Interim Quality Plan and On-site Review Protocol. The Quality Management Unit completed nine (9) Quality Services Reports which describe the review findings for one home health agency, two area agencies on aging, and six adult day centers. The Quality Management Unit provided technical assistance to agencies as their areas for improvement were revealed.

The Quality Management Unit Administered the Participant Experience Survey to 15 Consumers within this reporting period, making the total surveys administered to date 58.

Quality management activities have raised issues related to the formats and utilization of service planning documents such as the Case Management Action Plan. The Division is beginning to explore possibilities of an alternative format.