

# Vermont 1115 Waiver Demonstration

## Choices for Care Semi Annual Report January 2009–June 2009

This report covers the second and third quarters of year four in the operation of the Choices for Care Long Term Care Waiver Demonstration. A description of major accomplishments and activities follows.

### OVERVIEW

This report period is distinctly marked by the ongoing economic environment that began twelve months ago and continues at this time. Management of the budget and identifying a course of action to manage the waiver within this restrictive fiscal environment has caused difficult decisions to be made at the state level. The potential for more budget rescissions continues. Late CY2008 saw a reduction in the cap on the amount of time allocated to people receiving assistance with Instrumental Activities of Daily Living (IADL). Activities such as housekeeping, laundry, shopping, and money management were reduced from a maximum allotment of 5.5 hours per week to 4.5 hours per week. People who had been granted variances were not affected. Emergency rule making was required to effectuate this change. The final rule was passed in late January 2009.

As part of this same budget rescission, the Department of Disabilities, Aging and Independent Living (DAIL) filed an emergency rule that required participants in its general funded Attendant Services Program to apply to the Choices for Care program. A fuller description of that process was reported earlier. The final rule was passed in early February 2009.

The use of nursing homes and nursing home expenditures are higher than estimated under Choices for Care legislative appropriation. An anticipated 1.5% decrease in nursing home days from SFY '08, in fact, became a 1.5% increase, thus the trend has a net increase of 3% from the plan. Additionally, we had more enrollments in the Highest Need Group than planned and more of those participants than expected chose nursing home care.

We anticipate that budget discussions, reductions and recessions as well as the need for more efficient and innovative service systems will continue for SFY 10. This discussion could result in impacts on the service for CFC participants in home and community based settings (nursing home services are defined by CMS and State regulations).

Despite the budgetary losses, the Department was instructed in the SFY'10 budget, to increase the Adult Day Service cap for Moderate Needs from 30 hours per week to a maximum of 50 hours per week for individuals who need more time. This increase will have no impact on the budget as each provider's allocation is capped and the provider is responsible for serving individuals up to that cap. The Moderate Need Program does have a wait list for some services in some parts of the state between 9 and 4 individuals. The Adult Day providers, as a whole, did not exceed their cap in SFY '09. However, the increase in the cap could delay further the rate of individuals are removed from the wait list.

As of January, 56 individuals were on the High Needs Applicant list. A review of the case managers' monitoring reports was compiled to take a snapshot of what assistance these individuals were receiving while waiting for Choices for Care services. Of this group, 96% were receiving some type of support. Seventy-three percent (73%) received some level of support from an agency, 70% from family or friends, 11% resided in residential care or assisted living and received support from that entity. As of June 30 there was a total of 76 individuals on the list; 59 waiting for home-based services, 15 for enhanced residential care and 1 for nursing home care.

### **Highlights:**

A Participant Handbook was developed to assist new and current participants in understanding the type and scope of services they can expect to receive from the program. The development of this handbook was in response to some providers who felt that sometimes individuals may have unclear and unrealistic expectations regarding the delivery of services they can expect through the Choices for Care Program. A copy of this handbook was delivered to all participants through their case managers. New participants will receive a copy when they are visited by the case manager for their assessment. The handbook can be viewed at

<http://ddas.vermont.gov/ddas-publications/publications-cfc/choices-for-care-participant-handbook>

A Financial Eligibility Workgroup, comprised of representatives from the Department of Disability, Aging and Independent Living, the Department for Children and Families, and the Office of Vermont Health Access, has been meeting during this period. The purpose of this workgroup is to examine each Department's perspective regarding financial eligibility changes to the LTC program, identify options and work on implementation plans. It is anticipated that results of this work would only be effective after January 1, 2011 as eligibility changes cannot be made at this time by States that have accepted the federal stimulus packages.

The Long Term Care Task Force for Special Populations continues to pursue a variety of avenues to enhance the availability of services for individuals whose circumstances make it difficult to find community or institutional placements. This group includes the individuals from the corrections population who have maxed out their sentences, the untreated sex and drug abuse offenders, medically complex, and behaviorally challenged individuals. This task force has been successful in working with the Department of Corrections and the Vermont State Hospital to facilitate serving specific individuals who had been unable to be served. The most recent success was working with a Vermont nursing home (Crescent Manor) to create a specialized unit for individuals with Huntington's Disease. The new unit was opened on April 1 and currently has four residents. The facility is expecting to be able to fill the four remaining openings soon. This new unit will allow DAIL to bring back individuals who are currently receiving services out of state; a savings for the State and a benefit to the resident and family members.

The Nursing Home Dollars and Days workgroup is charged with examining the state of the nursing home industry, monitoring monthly utilization and financial status, review the current statutory authority of the state over the industry and identifying strategies to ensure adequate service in the state while continuing to shift the balance in the long term care system. Over the past year, Vermont has had a nursing home's parent company file for Chapter 11 bankruptcy protection and two other nursing homes have requested extraordinary financial relief. The Department is of the position that we must update and improve our ability to address and respond in critical situation that may arise, particularly in this economic environment.

The Department for Children and Families is currently undertaking a large scale redesign to modernize the human-services infrastructure with

a goal of improving access to benefits, staff morale, and client satisfaction. This effort is referred to as the Modernization of Benefits Eligibility Project Commission. DDAS is a member of the team that is working on the long term care portion of this effort. The first part of the project was to develop the project specifications; the second is to begin the project development phase. For long term care, the first decision and product was the consolidation of the former two LTC applications (one for clinical and one for financial determination) into a single application. This single application went into effect in April, 2009. While there is some speculation that this new application has had a negative impact on the number of referrals and applications to Choices for Care, there is no hard data to support that hypothesis. DDAS is asking case managers for case specific examples in order to better assess the impact of this new application.

## **QUALITY MANAGEMENT**

As a direct result of the three budget rescissions in SFY09, the Department lost over 30 positions. These losses necessitated a restructuring of DDAS. Units were redefined and the Quality Management Unit was disbanded. Half of their staff was affected by the reduction. The remaining Quality Management staff was re-assigned to other units. No quality management staff was assigned to the Adult Services Unit, where Choices for Care resides. The State Unit on Aging is responsible for designing a new quality plan that will look across programs. This unit will oversee the quality programming for the Choices for Care programs. Workgroups have been formed to design a plan that addresses the needs of all programs for the aging and adult's with disabilities populations. This is in recognition that many of the providers and consumers of services in Choices for Care are also providers and consumers funded under the Older Americans Act (OAA). Blending the quality management process for CFC with OAA appears to be a logical plan. At this point a quality review plan is being tested in the Adult Day Service system. Home Health Agencies and Residential Care facilities are reviewed by regulation by the Division of Licensing and Protection (DLP). The Choices for Care staff, in concert with the quality review staff, will coordinate with DLP regarding compliance matters and complaints.

The University of Massachusetts Medical School, Center for Health Policy Research (CHPR) is the contractor engaged to evaluate the Choices for Care Demonstration. As part of that contract, they issue policy briefs in a number

of program and policy areas. The most recent brief was quite timely as it addressed the topic of quality oversight in Choices for Care. This document was finalized during the initial period of re-examining the quality process for (DDAS). The recommendations in this report have been positively viewed by the Division and a workgroup has been formed to review and develop implementation strategies based upon these recommendations. In brief, the report recommends developing a quality review system that looks at quality through the case management system in recognition that this service would hold the most comprehensive information on how an individual's needs are being met. This report can be view at <http://ddas.vermont.gov/ddas-publications/publications-idu/publications-idu-documents/umass-quality-policy-brief>.

## **PACE VERMONT**

As of June 30, 2009, the PACE program option had a total of 73 participants between the two sites; 43 at the Colchester site and 30 at the Rutland site. This indicates a slow but steady increase in enrollment, although well below the budgeted target. In January, the PACE program sponsor, PACEVERMONT, approached the state with their concerns regarding the lack of enrollments, level of referrals and the level of care determinations and their financial viability. PACEVERMONT presented several options for consideration by the state to address their pending financial instability. As a result of these discussions, the Department joined with the National PACE Association to hire a team of consultants to perform a PACE Peer Review audit. This team was charged with examining the organization in four topic areas: Leadership, Marketing/Enrollment, Financial Management and Interdisciplinary Team. A copy of this report has been made available to both the Regional and Central Offices of CMS. Subsequent to this review, regular meetings have and will continue to take place with State staff, PACE staff and CMS Regional and Central Office staff. The purpose of these meetings is to closely monitor the financial viability of the sponsoring organization. State staff has been working extensively with the PACEVERMONT staff to address particular programmatic areas and process challenges in order to assist in the timely enrollment of individuals who elect PACE as their long term care option. An article was developed, which will be published in the Vermont Medical Society newsletter describing the PACE option with the goal of enhancing the understanding and, hopefully, increase referrals from the local medical practitioners.

## **EVALUATION**

The University of Massachusetts Medical School, Center for Health Policy and Research (CHPR), is under contract to evaluate the Choices for Care Demonstration Waiver. Previous reports have illustrated the scope of work they are under contract to perform and the documents developed to date. As part of this process, CHPR continues to develop their series of Technical Assistance and Policy Briefs. During this period, they have completed the Quality Oversight policy brief, as noted above. A summary of their technical assistance for 2008-2009 is attached.

As mentioned in the last report, CHPR conducted an analysis of the 2008 consumer survey conducted by ORC-MACRO. This consumer survey reaches beyond the Choices for Care consumers; however, it does give a comprehensive view of how satisfied consumers are with Choices for Care as well as other Department services. This analysis is intended to capture Choices for Care's status at the mid-point of the demonstration. This report (*CFC 2008 Outcomes at a Glance*) is limited to analyses of the selected survey responses of CFC clients related to the first five short-term outcomes and two long-term outcomes. The seven identified short-term (i.e. 1-5 years) desired outcomes were: Information Dissemination, Access, Effectiveness, Experiences of Care, Quality of Life, Waiting List Impact, and Budget Neutrality. In addition, the waiver established two long-term outcomes that may be reasonably expected to take longer than five years to achieve: Public Awareness and Health Outcomes. This report is attached.

A companion report, *CFC Evaluation for Years 1-3 (2009)*, provides a more comprehensive summary of evaluation data of CFC between 2005 and 2008. This report is still in draft form and will be included in the next report.

## **REPORTING OF DATA**

Vermont tracks a number of processes and reviews outcomes in a variety of areas in order to manage the Choices for Care waiver. These include, but are not limited to:

1. Managing applications, enrollment, and service authorizations;
2. Tracking current and retroactive eligibility
3. Tracking real-time trends in applications, enrollment, service authorizations, service settings, individual provider performance, service utilizations, and service expenditure;
4. Analyzing expenditures using both cash and accrual methodologies;
5. Predicting future service utilization and costs using both cash and accrual methodologies.

Multiple data sources are used for these purposes, sources may not be integrated or use the same methodologies for entry and extracts. For example, clinical eligibility determinations are tracked in one data base while financial eligibility determinations are traced in another. The clinical data base might indicate an approval, while the financial eligibility data base is still pending or determined ineligible or vice versa. **Due to the different methodologies and purposes for the databases, please note that information reported on the CMS64 reports does not match information from other data sources or program reports.** Program reports for this reporting period can be viewed at <http://ddas.vermont.gov/ddas-publications/publications-idu/publications-idu-documents/choices-for-care-quarterly-data-report> and July is attached as it has not been posted as of this writing.

## **EXTENSION**

Per the Terms and Conditions, Vermont is required to submit a request by September 30 if we intend to re-new or extend the waiver. The State Legislature, in the SF '09 Appropriations Bill required that “the department convene a working group from its advisory council for the purpose of providing input on the advisability of seeking renewal of the waiver and how with any new waiver there can be timely reporting to providers and consumers on reinvested savings.” Beginning September 2008 the Departments advisory group meeting has been extended an additional two hours and expanded to include providers, consumers and advocates dedicated for the purpose of the waiver and its renewal. This group has agreed to request an extension rather than a renewal. With respect to the legislative language regarding savings, the Commissioner explained that this language is not accurate since with one budget, the budgets for nursing facility services and home and community

based services are one in the same and DAIL manages the demonstration with that single appropriation.

The group has met monthly for seven months covering a myriad of issues and topics. Some topics considered include: should Choices for Care continue to be a separate 1115 waiver from Global Commitment 1115 waiver; should other like services (TBI, Developmental Services, Attendant Services Program) be moved into Choices for Care, have there been any unintended consequences, what changes, if any, should be made to the Moderate Needs Group, how are we addressing workforce issues of supply and demand? We expect to continue these discussions during the next year to cover these and other issues regarding the Choices for Care Waiver.