

# **Vermont 1115 Waiver Demonstration Choices for Care Quarterly Report October 2005 – December 2005**

## ***Summary:***

On October, 1 2005 The State of Vermont launched their new 1115 Long Term Care Waiver Demonstration Program Choices for Care. The intent of this demonstration is to undertake a broad based reform of the long-term care service system by offering a continuum of care that includes a series of options, including both home and community- based alternatives and traditional nursing facility services. All persons who meet the clinical and financial eligibility for long term care Medicaid for highest need are immediately enrolled in Choices for Care. Individuals who meet the high need criteria are placed on a waiting list with the intent of enrolling them in the program once a determination is made that they can be supported within the budget neutrality limits. In the interim, they are monitored monthly and linked to appropriate community services. Additionally, a new expanded group, the Moderate Needs individuals, has been established with particular financial and clinical criteria. This demonstration group receives a limited service package comprising of limited case management, adult day service and homemaker service. The proposition is that by offering a low cost service to individuals before they become eligible clinically for long term care, we can delay their need for a more costly service package and keep them at home longer.

## ***First Quarter Events:***

On August 15, 2005 twelve (12) nurses were hired and started an intensive training session in preparation of the program start. For six weeks, the nurses attended daily training session on all aspects of the Choices for Care program, the service delivery system and related

resources. Prior to October 1, each nurse acquired a locally based office and “opened for business”. The Long Term Care Clinical Coordinators (LTCCC) are charged with determining initial and ongoing clinical eligibility, approval of service plans, provision of technical assistance to all partners, provision of options counseling to program applicants, ongoing utilization review, staffing local waiver teams and outreach and community relations.

On August 26, a letter was sent to all current nursing facility resident and home and community based participant announcing the new Choices for Care Program.

From July through December, monthly VIT (Vermont Interactive Television) sessions were held for providers. Topics ranged from updates on start up activities to review of policies, procedural changes and forms to be used to facilitate the program operations.

On October 7, 2005 the Choices for Care Regulations were approved.

Weekly meetings with EDS (the Medicaid claims processing entity), DCF/Economic Services Division (the financial eligibility determination entity), OVHA (the Medicaid oversight agency) and DDAS (Division of Disability and Aging Services) staff were held and continue to this day. The purpose of this group is to ensure that the work of these three systems coincides and to create a smooth operational process for eligibility, claims processing and service delivery.

The Division of Licensing and Protection (DLP) offered guidance and technical assistance with clinical determinations and in establishing working relationships with the nursing facilities. The relationship to facilities was previously in the purview of DLP. With the new long term care system that contact for patient eligibility was transferred to DDAS.

On October 1 all nursing home residents and community based participants were migrated into the SAMS data base system. A total of 3,447 individuals were automatically enrolled in Choices for Care. 2286 were nursing facility residents, 988 were home and community based resident and 173 were enhanced residential care residents. As of December 31, 2005 there were 3710 individuals enrolled – 2216 nursing facility residents, 1297 home and community based individuals and 197 enhanced residential care residents - a net gain of 263 individuals.<sup>i</sup>

As of December 31, an additional 163 nursing facility residents, 162 home and community based individual and 26 enhanced residential care residents were found clinically eligible but were pending financial eligibility.<sup>ii</sup>

The waiting list for High Need individuals was 52 as of December 31, 2005.<sup>iii</sup> Prior to Choices for Care the home and community based program had 241 individuals awaiting a “slot” to receive services.

Average service plans have decreased over the first quarter. In October home based plans averaged \$3,655 and ERC plans averaged \$1,794. As of December 31, home based plans were reduced to an average of \$3,629 and ERC plans were reduced to \$1,772.<sup>iv</sup> Nursing facility paid Medicaid days were reduced from 70,037 in September to 65,968 in December.<sup>v</sup>

The integrity of the data at this time gives an inaccurate picture of expenditures during this quarter. Adjusted claim data indicate the following expenditures:<sup>vi</sup>

Paid claims	October '05	November '05	December '05
Home based, including moderate	\$2,261,219	\$2,490,322	\$3,344,840
ERC	\$248,600	\$219,353	\$292,522
Nursing Home	\$8,619,253	\$8,600,074	\$8,637,174

### ***Progress of Quality Assurance Activities:***

As part of the Real Choice Systems Change QA/QI Grant, the Quality Management Committee met in October, November, and December, to discuss values in service provision in order to develop potential desired outcomes of services in the following quarter.

During the month of October work began on the development of the *Choices for Care Interim Quality Plan*.

### ***Notable Accomplishments:***

The most notable accomplishment was that the program was initiated without any disruption of service to the current participants.

Program was initiated with a full complement of LTCCC and program was instituted state wide.

Providers were trained through ongoing VIT session, waiver team meetings, provider meetings and individual contacts.

As we planned, individuals who submitted an application for long term care services are contacted for an assessment appointment with the LTCCC within three days of receipt of an application.

The waiting list for long term care services was significantly reduced.

The Long Term Care Ombudsman contract was negotiated and expanded to include community based participants.

Enhanced Residential Care services experienced a relatively smooth transition.

Initial data indicates an increase in use of ERC homes, home based services and a decrease in Medicaid paid nursing home beds.

Responsiveness of staff to problem resolution and development of new forms to enhance communication has been a top priority and will continue with the goal of creating a smoother system.

### ***Problems identified and resolution activities:***

Nursing facility providers were initially concerned with respect to payments for nursing facility admission. Their reluctance resulted in some admission delay and back up in the hospital discharge system. Meetings were held and a memorandum to the facilities and hospital discharge planners clarified the admissions process and relieved confusion and concern.

New procedures with regard to patient share also added confusion and required clarification with providers.

Case managers experienced confusion and concern over their new role and that of the LTCCC. Ongoing waiver team meetings, VIT sessions, provider meetings and open communication by the LTCCC and state staff have resulted in an increased understanding and clarification of roles.

Agencies who acted as the Designated Administrative Agencies under the old waiver continue to have difficulty with their perceived sense of loss of control and information. Ongoing discussions with each group are continuing. It is anticipated that the passage of time will lessen this concern as the new system becomes the norm.

Negotiations during the regulatory process resulted in changes to the financial eligibility for moderate need individuals that were not intended in the program design. Individuals who were previously expected to be eligible were not. This led to confusion for providers and consumers. An exception to the rule was implemented which allowed these individuals to be re-instated for adult day services. Revisions to the regulations will be required to adjust the financial eligibility for the Moderate Needs Group reflective of the original design intent.

Billing issues developed as a result of new procedures and edits have emerged. Weekly meetings continue between EDS, DCF, OVHA and DAIL. Priority staff attention has been given and will continue to resolve these issues. Delays in billing have also resulted in inaccurate financial expenditure data.

The volume of data transferred into the new data base system created delays in data entry and questions of data integrity. Ongoing clean up of the data has resulted in better data. This cleanup is expected to be ongoing into the next quarter.

The volume of applications from all settings created a delay in processing applications. Discussion with DCF is ongoing to find methods to address these delays.

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<sup>i</sup> Active participants by setting & loc.306brh4/3/06

<sup>ii</sup> Received pending application.306brh4/3/06

<sup>iii</sup> High needs wait list by county.122906brh12.29.06

<sup>iv</sup> Approved poc costs erc & hcbs.3064/3/06

<sup>v</sup> 2/3/06Act160-06.xlwjim's monthly

<sup>vi</sup> 2/3/06Act160-06.xlwjim's monthly