

Vermont 1115 Waiver Demonstration

Choices for Care Semi Annual Report July 2008 –December 2008

This report covers the fourth quarter of year three and the first quarter 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 current economic environment that began at the start of the fourth quarter in FFY 08; continues through the first quarter of FFY 09 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 consumed much of our time. A budget rescission in August required the Department to make changes in the Choices of Care budget, reducing 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 were receiving 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 the budget rescission, the Department filed an emergency rule that required participants in its general funded Attendant Services Program to apply to the Choices for Care program. The Attendant Services Program was established in 1980 to assist individuals with disabilities who wanted to work but needed hands-on assistance in order to do so. As participants aged in place, many of them qualify for home based long term care services. Individuals remained on the ASP program because under that program they were able to pay their spouse to provide ADL and IADL services. Since Choices for Care now allows spouses to be paid for providing ADL care it seemed like a logical progression to move some Attendant Services participant

into Choices for Care. This transition took place over the fall and into the winter. The final rule was passed in early February, 2009. The transition is continuing but an estimate of individuals to enroll in Choices for Care is still unknown. A concession was made during the rule-making process as Choices for Care does not currently allow spouses to be paid to provide IADLs. Individuals who have moved or are in the process of moving may stay in the Attendant Services Program if they want to continue having their spouses paid for IADLs. Many individuals will stay on Choices for Care as the benefit package is greater than in the Attendant Services Program. In Choices for Care, individuals may receive adult day service, respite/companion services, personal emergency response system and funds for assistive devices/home modifications.

The use of nursing homes and nursing home expenditures are higher than budgeted under legislative allocation. The Department is discussing possible approaches to further reducing nursing facility use, including examining adult foster care (24 hour setting in the community). We continue to have discussions with our CMS partners on this topic. One obstacle is that providers of 24 hours service in the community in Vermont are mainly providers of service to individuals with developmentally disabled. We propose modeling a system for Choices for Care recipients similar to this system. Financial reimbursement challenges are being discussed to determine if we can apply the reimbursement mechanism used in the Developmental Disability Service System for CfC participants who may be temporarily hospitalized in order to maintain the home provider's availability when the individual returns to the community.

We anticipate that budget discussions as well as efficient and innovative service systems will continue for SFY 09 and into SFY 10. This discussion will mostly likely have an impact on service authorization for CFC participants in all settings.

HIGH NEEDS APPLICANT (WAIT) LIST

Advocates expressed their concern about what they considered to be a misnomer in using the term "wait list". At their suggestion, this list has been renamed the High Needs Applicant list. As noted in the previous report, the High Needs Applicant List continues to be in place as a tool to control expenditures. There were 48 individuals statewide on the applicant list as of

December 2008. This is in comparison to the 241 individuals that were listed at the beginning in September 2005. The program regulations include the ability to enroll certain individuals on the applicant list, under “special circumstances”, e.g. loss of a primary caregiver. The ability to create an applicant list (wait list), when needed, was an essential element of the original Choices for Care waiver proposal and was approved by CMS and the Vermont Legislature.

A comprehensive analysis of enrollment and the waiting list completed by the evaluators from the University of Massachusetts Center for Health Policy and Research is attached.

MODERATE NEEDS

The Moderate Needs enrollment process, developed earlier in the year, continues to provide the needed communication flow that previously hampered the program. During the course of this period, providers expressed their concern regarding the level of need of individuals applying to the Moderate Need Group and the impact on their ability to adequately serve them. Not surprisingly, as the High Needs applicant list was instituted, individuals who do not qualify for Highest Needs are going on to the Moderate Need program as a way to ensure some level of service. This has impacted on the availability of funds to serve Moderate Need individuals in the two service components- adult day service and homemaker service. Another challenge has been in the amount of homemaker service delivered to individuals. The program limits are “up to” six hours per week. The perception of participants is that they should receive six hours per week. DAIL and the providers have attempted to clarify this for participants. The reality is that many individuals require less than that amount of time for homemaker services but have other unmet needs that could be met with other services. The providers are also challenged by the lack of adequate staffing in this service arena.

CHALLENGING PLACEMENTS

The Department continues to identify barriers to our ability to appropriately meet the long term care needs of individuals who have particularly challenging complex physical and/or behavioral conditions. These challenging individuals might be persons who are difficult to discharge from the local hospital and/or from the Vermont State Hospital because there are no other identified

appropriate settings that will accept them. Other challenging placements are individuals in the correctional system that have long term care needs and are completing their sentences. As expected, traditional community providers have limited ability and experience in serving individuals with challenging behaviors and complex medical conditions and many nursing homes are reluctant to serve them because of safety concerns for other residents, concerns about public perception of the facility and what they characterize as inadequate reimbursement.

A protocol was developed to assist the Department of Corrections in discharge planning for these individuals. This protocol was based upon the protocol developed with the Vermont State Hospital. A copy of the protocol is attached. The use of the protocol will help corrections staff in appropriately accessing the provider network in the course of their discharge activities; however, the ongoing challenge is the availability of appropriate service providers for this challenging set of individuals.

In an effort to develop new provider capacity, DAIL submitted a proposal in August 2008 to CMS for an Individualized 24 Hour Care also referred to as Adult Foster Care option. The full implementation of this option is limited in part by concerns brought to DAIL from the providers who are participating in the test model currently underway. These providers rely on contracted home providers as the base of their service delivery system. Providers have made it clear that they can not afford to offer this service without a funding mechanism that would allow them to continue to reimburse their home providers for a period of time (typically up to 30 days) while a client is in the hospital or in a temporary nursing home stay. To address this barrier, DAIL submitted a proposal for consideration by CMS, to provide a Personal Care Capacity Payment. The request for a Personal Care Capacity Payment was denied by CMS. A lengthy set of questions in response to the 24 Hour Care proposal was received from CMS. DAIL has not yet responded to those questions. Budget issues have caused this program development option to remain in the background until a later time. DAIL remains committed to this option and intends to pursue it further later in the year.

QUALITY MANAGEMENT

The Quality Management Unit is responsible for monitoring the Choices for Care providers (excluding Enhanced Residential Care Home providers and nursing facilities, which are surveyed by the Department's Division of Licensing and Protection). Implementation of the Quality Management Plan and its review processes took place in July 2007.

The Real System Change Quality Assurance/Quality Improvement grant ended on September 30, 2008. The purpose of the grant was to develop new service standards for quality design and delivery of services across the Home and Community Based waivers in DDAS. This included Choices for Care – long term care waiver, Developmental Disabilities program and the Traumatic Brain Injury program. The last two programs are part of Vermont's other 1115 Waiver – Global Commitment. A major focus of the initiative was to utilize the CMS HCBS Quality Framework. A copy of the final report is attached.

In July 2008 quality management reviews were suspended. The current Division (DDAS) quality management plan provides a set of quality service outcome and indicators which were used across all programs. After receiving feedback both internally and from service providers, DDAS is making revisions to address specific outcomes for each Choices for Care provider type: Adult Day Services, Home Health Services and Area Agency on Aging Services. Workgroups consisting of service providers and DDAS staff have been meeting since September, 2008 and are revising the review process in each program area. Consumer and family member input is also being sought as part of this process. It is expected that the first drafts of a revised quality services review process for each program area will be completed by February 1, 2009. Revisions will be finalized in spring and a "roll out" will begin by summer.

DDAS continues to meet quarterly with the Long Term Care Ombudsman to discuss Ombudsman findings and possible improvements to the Choices for Care program. All complaints by consumers in the Choices for Care program are brought to the Ombudsman and reviewed. During the FFY 08, 65 Choices for Care related complaints were responded to by the Ombudsman. This includes complaints against the CfC providers, DAIL, the LTCCC's, OVHA, and Medicaid.

FLEXIBLE CHOICES

Flexible Choices is Vermont's version of the "Cash and Counseling" model, in which an individual's service plan is translated into a person-centered budget. The Flexible Choices option allows for more flexibility in purchasing services and goods that the individual has determined will meet his/her unique needs. This often involves services and goods that are not available under the "traditional" program, but are necessary for the care and support of the individual.

This program is now fully integrated into Choices for Care as a service option. A final report on the RWJ Case and Counseling grant is attached.

A direct outgrowth of this initiative was the development of a web-based Direct Care Worker Registry. A contract with Rewarding Work was developed and in the fall of 2008 the Direct Care Worker Registry was launched. This is a free web-based product, with telephone support available, which will match willing workers with employers, both consumers and agencies, who need caregivers. Currently there are over 300 workers and 200 employers signed up in the registry. Activities included development of worker recruitment brochures, posters and a mailing to current workers to introduce the web site. PSA announcements and press releases continue to announce the availability of the site which can be accessed at www.RewardingWork.org/Vermont.

PACE VERMONT

At the end of December 2008, PACE-Vermont had a total of 64 participants between the two sites; one site is in Colchester and one site is in Rutland. This indicates a slow but steady increase in enrollment.

During the past six months, PACE has reported difficulty recruiting individuals for the program. The establishment of the High Needs Applicant list has had a significant impact on this program option. The financial structure of the program depends on the clinical diversity of enrollees. The nature of that structure requires a range of clinical need in order to maintain a financial balance. With the inability to enroll lighter care needs of the High

Need individuals, the program is left serving the neediest individuals. This naturally affects the budget and assumptions it was built upon.

During this period, PACE underwent a pre-audit review in anticipation of CMS's site visit in December. The DDAS staff assisted CMS in this three-day review. As of this report, PACE Vermont is responding to the findings from that review.

In November DAIL revised the reimbursement rates to PACE Vermont. As a result, they received a net gain in the "dual eligible" cap and a small net loss for the "Medicaid-only" cap. The Medicaid capitations factored in the actual historical expenditures, moving away from the initial rate setting which was based upon actuarial computations.

DAIL staff continues to work with PACE and CMS in approving the final enrollment documents.

EVALUATION

On June 15, 2007 a contract was awarded to the University of Massachusetts Medical School, Center for Health Policy and Research (CHPR), to undertake the evaluation of Choices for Care. The contract requires a multi-level approach. CHPR, working with the University of Vermont, has completed focus groups and interviews of consumers, family members, providers, and state staff. These focus groups are intended to identify and elucidate issues related to the implementation and management of Choices for Care.

As part of this process, CHPR continues to develop their series of Technical Assistance Briefs. During this period, they have completed the "Enrollment and Waiting List" policy brief.

The 2008 consumer survey conducted by MACRO is also attached. 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.

Additionally, the responses of the MACRO survey will be forwarded to CHPR for analysis, to be linked to the SAMS data (DDAS data management system) which encompasses service authorization and point-in-time ILA (CfC assessment tool) to a multivariate analysis.

LONG TERM PARTNERSHIP PROGRAM

On February 8, 2006, the Deficit Reduction Act of 2005 was enacted. The legislation lifted the moratorium on the establishment of new partnership programs and allows all states to implement long-term care partnership programs. Vermont statute 33 authorizes the secretary of human services, in consultation with the commissioner of Banking, Insurance, Securities, and Health Care Administration (BISHCA) to establish by rule the Vermont Partnership for long-term care. While the DRA removed federal obstacles for the implementation of a partnership program in Vermont, there remain some policies that are inconsistent with the Vermont statute. Enactment of new legislation must be accomplished in order to implement the partnership program in Vermont. Necessary amendments to legislation include:

- The requirement that Vermont adopt certain National Association of Insurance Commissioners long-term care model regulations.
- The condition that Vermont may not impose requirements on partnership policies unless the same requirements apply to non-partnership policies.
- The requirement that long-term partnership policies contain age-specific inflation protections consistent with the DRA.
- The requirement that producers who sell only-term care policies be trained in and demonstrate an understanding of the protections offered to purchasers of long-term care insurance and how the insurance relates to public and private coverage of long-term care.

Thus, enactment of new legislation must be accomplished in order to implement the partnership program in Vermont. This legislation would authorize Vermont to participate in the long-term care partnership program, where by a Vermonter who purchased a certified long-term care policy could protect his or her assets up to the amount of benefit payments made to or on behalf of a beneficiary under a partnership

policy. S 343 (Legislation Enabling The Vermont Partnership for Long-Term Care Program) was introduced in 2008 and passed by the Senate on January 29, 2008. The bill was referred to the House Human Services Committee; however, neither this Committee nor the House voted on this bill.

In the meantime, the Economic Services Division promulgated Medicaid eligibility rules necessary to bring Vermont's eligibility standards into alignment with the DRA. BISCHA staff, ESD staff and staff from the Department of Disabilities, Aging and Independent Living continue to work together concerning the implementation of a partnership program in Vermont. Meetings have been held, including representatives of the providers systems, other state agencies, advocates and long-term care carriers with the purpose of addressing technical and practical issues concerning the development of a partnership program in Vermont as well as other issues concerning long-term care insurance generally. A result of these meetings was the drafting of a proposed Long-Term Care Regulation that BISCHA filed with the Interagency Committee on Administrative Rules on January 13, 2009. BISCHA will regularly report to the general assembly the process and evaluation of the program. Future development will be dependent upon further legislation being acted upon to bring Vermont law into compliance with the federal requirements of the DRA.

REPORTING OF DATA

Vermont tracks a variety of process 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 may 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 may be viewed at the website of the Department of Disabilities, Aging and Independent Living at <http://www.ddas.vermont.gov/ddas-publications/publications-idu/publications>.

Summary of Challenges:

- In SFY 2008, financial pressures led to the return of the waiting list for High Needs Group applicants. This waiting list has reduced the number of people who could be served in the community.
- In SFY2009, increasing financial pressures led to a reduction in assistance with IADLs. Ongoing financial pressures are expected to lead to more efforts to reduce expenses in SFY2009.
- Many providers are facing increased financial pressure as their expenses increase and reimbursement rates do not increase.
- Vermont's long term care system is challenged to serve some people with complex physical and/or behavioral conditions, including some people leaving the Department of Corrections and the Vermont State Hospital.
- Because of a limited workforce, some people have difficulty finding caregivers and do not receive all the services that they are authorized to receive.
- Difficulty in accessing other resources and services (housing, transportation, food, fuel and energy) continues to present obstacles to some people seeking to remain in their own homes.

