

# Vermont 1115 Waiver Demonstration

## Choices for Care Semi Annual Report July 2009–December 2009

This report covers the fourth quarter of year four (4) and the first quarter of year five (5) in the operation of the Choices for Care Long Term Care Waiver Demonstration. A description of major accomplishments and activities follows.

### OVERVIEW

This period continued to be marked by the ongoing downturn in the economic environment that began eighteen months ago. Management of the budget and identifying a course of action to manage the waiver within this restrictive fiscal environment has required difficult decisions to be made at the state level. Providers of services in the Choices for Care program saw a 2% reduction in rates during this period, and nursing homes had to forego their annual inflationary increase. This period also marked the beginning of activities related to requesting an extension of the demonstration waiver for an additional three (3) years. Actions that have been taken and decisions that have been made as a result of these two areas are discussed below.

Based on the Department of Disabilities, Aging and Independent Living's (DAIL) internal financial monitoring, the financial expenditures for Choices for Care were under budget as of November 2009. The number includes the long term care costs as well as the acute care costs; however, it is anticipated that there will be additional costs due to an 2008 settlement with the Vermont Veteran's Home, anticipated emergency financial relief requests by two other nursing facilities, and an increase in rates charged by an out-of-state facility.

As part of the waiver extension process, the Commissioner appeared before the Health Access Oversight Committee to provide an update on CFC and request for the CFC waiver extension. The Commissioner received a positive response on moving forward with the request for an extension.

In the last Legislative session, the Legislature directed DAIL to investigate the feasibility of allowing Vermonters to receive services under Choices for Care

while also receiving hospice benefits under Medicaid or Medicare. Currently, Choices for Care does grant a variance for dual program access to individuals already in Choices for Care who elect Hospice and would be harmed by losing their current caregivers. This new approach would allow individuals to access Choices for Care after elected Hospice services. This report is expected to be completed soon.

### **Highlights:**

As mentioned in the previous report, DAIL meets monthly with our Advisory Board and has sought input on the advisability of seeking an extension of the CFC waiver. Over the course of these meetings, the Advisory Board agreed with the Department that these times are not ripe for a full renewal, but rather it would be more prudent to request an extension. A letter from the Governor requesting this extension was submitted to CMS in September 2009. A detailed description of that process is noted further on in this report.

The Financial Eligibility Workgroup continues to examine changes that if enacted, would produce savings/cost avoidance in the future. Most recently, the Commissioner met with Legislative leaders to review proposed changes and improvements to the lien, collections, and financial eligibility processes. The initial response has been favorable. Additionally, DAIL has planned several meetings with advocates to hear their input on this issue and will continue to meet over the next few months. The Legislature will take testimony on the proposed options and determine whether it wants to include enabling language in the state budget for state fiscal year 2011 (July 2010-June 2011).

As a result of the public hearing on the waiver extension request, it was determined that DAIL was not in compliance with the Terms and Conditions regarding the High Needs Wait List and the continued enrollment of new applicants to the Moderate Needs Group. A course correction was made which resulted in the need to freeze enrollment in the Moderate Needs Group as long as there is a High Needs Wait List. This freeze went into effect in November 2009. DAIL continues to monitor the financial status of Choices for Care expenditures on a monthly basis with the hope that a favorable financial picture will allow us to enroll some individuals from the High Needs Wait List.

### **QUALITY MANAGEMENT**

As noted in the last report, the Division of Disability and Aging Services (DDAS, or Division) recently restructured and incorporated the Quality Management Unit into other units in the Division. A workgroup has been formed with representation from the State Unit on Aging and the Adult Services Unit to identify new methods of quality assurance.

The University of Massachusetts' 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.

The Case Management Quality Workgroup is in the process of developing a plan that will incorporate adequate quality assurance and improvement activities for CFC and Older Americans Act case management services within the available but limited state staff resources. This plan will focus on Case Management Agency Certification, Case Manager Training Curriculum, the development of a DDAS Complaint System, and continuation of the current DDAS activities related to QA/QI. This last item includes the MACRO Satisfaction Survey, Area Agency on Aging Area Plans, Home Health Agency licensing surveys, Long-term Care Ombudsman Program, Long-term Care Clinical Coordinators' (LTCCC's) utilization review, waiver team meetings, quarterly case management supervisors' meetings, provision of technical assistance, and targeted training to agencies as identified.

### **PACE-VERMONT**

Regular meetings 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 PACE VERMONT 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. In order to address their financial situation, PACE-VT issued a

Request for Proposals seeking organizations that might want to partner with them regarding sponsorship of PACE-VT. A result of this was the formation of a new partnership between Volunteers of America and On Lok, Inc., two not-for-profit organizations. This new partnership was accepted by PAC-VT and as of January 2010 this organization became the new PACE sponsor. This has resulted in an infusion of funds into PACE to stabilize their financial status.

## **EVALUATION**

As noted previously, the University of Massachusetts Medical School's 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 demonstration 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 can be read at <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-outcomes-at-a-glance>

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 can be found at <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys>.

## **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 expenditures;
4. Analyzing expenditures using both cash and accrual methodologies; and
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 database while financial eligibility determinations are traced in another. The clinical database 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>

## **EXTENSION**

Per the Terms and Conditions, Vermont was required to submit a request by September 30, 2009 if we intended to renew 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 Department’s advisory

board meeting was been extended an additional two hours and expanded to include providers, consumers and advocates dedicated for the purpose of the waiver and its renewal. The advisory board 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 and the same and DAIL manages the demonstration within that single appropriation.

The extended board meetings occurred each month 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; and how are we addressing workforce issues of supply and demand?

In September 2009, CHPR presented it's evaluation report to the DAIL Advisory Board as part of the review process and discussion. A copy of the report is available at:

<http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/umms-presentation-dail-advisory-brd>

In October, 2009 the DAIL Advisory Board invited advocates, providers and the public to attend a meeting to provide input into the request for an extension for an additional three year period from October 2010 through September 2013 of the VT 1115 Demonstration Long Term Care Waiver – Choices for Care. It was noted that since this was an extension and not a renewal, DAIL cannot make any changes in eligibility criteria; however, changes in the services provided may be made. The following opinions were expressed by members of the public at the October 2009 meeting:

*High Needs Wait List:*

- *Concern that the Department was not following the terms and conditions of the waiver by expanding Moderate Need services while a High Needs Wait List was in place.*
- *Any extension of the current waiver must require assurances that all funds appropriated for CFC are retained by CFC, are used to fund*

*the high needs group, and when that is fully funded, to fund moderate needs group.*

- *Concern that High Need individuals bypass the waiting list when discharged from a hospital to nursing home. The waiver should be able to serve both [services to high need in the community and in nursing home] regardless of setting.*
- *The waiting list is a “freeze” list, where there is no turnover.*
- *The high needs group is not being prioritized as called for repeatedly in the existing terms and conditions.*

#### *Application Process:*

- *The Department of Children and Families’ and DAIL’s decision to develop a single application may create a barrier to access and extend delays in eligibility determination.*
- *Any extension of the current CFC waiver must ensure that any Vermont resident aged 18 years or older wishing to do so will be permitted to complete an application of CFC.*
- *Concern regarding the delay in processing financial eligibility.*
- *Recommendation of a streamlined process for patient who have completed the application process in the past by requiring only an annual update of financial information.*

#### *Notices:*

- *The notices provided to deny CFC or to reduce services in CFC are inadequate as a matter of law.*
- *The Department’s notices to CFC applicants and beneficiaries should now, and must under any extension of the waiver, meet minimum due process standards.*

#### *Clinical Assessment Process:*

- *The Department may not be adequately applying these criteria thus, denying nursing home level of care to individuals who have an additional mental illness.*
- *Any extension of the CDC waiver must ensure that the long term care needs of eligible individuals with coexisting mental illness are met regardless of the existence of the mental illness.*
- *Any extension of CFC should implement PASARR screening properly, and the Department needs to resolve any interdepartmental or*

*funding issues regarding fully serving the long term care treatment needs of the mentally ill.*

- *Nursing facilities should be able to determine clinical eligibility and submit documentation to DAIL.*

#### *Assessment Process:*

- *Views the assessment process that asks clients to demonstrate functional abilities as demeaning and demoralizing.*
- *Concern that LTCCC's are not taking into account the responses of others in their assessment of individuals with dementia.*
- *Assessment tool, especially bed mobility, is not generally part of services that are offered during the day, especially since CFC does not pay for 24 hour care.*

#### *Other:*

- *An extension of the current waiver must ensure that decisions regarding clinical eligibility and level of service are consistent across the state and are need rather than budget based.*
- *CFC funds should follow the people instead of being assigned to facilities or specific counties.*
- *Some CFC programs should be opened up to private duty organizations.*
- *Any waiver extension should include a clarification of how savings are defined and induce provisions that protect and preserve saving for the CFC program.*
- *DAIL should be committed to greater transparency in its administration of a waiver extension.*
- *Any renewal should require the state to use its inspection and enforcement authority to protect these {ERC} residents.*
- *There is not a comprehensive assessment of the existing infrastructure capacity or future infrastructure need in each count to achieve the state's goal of 50/50 balance between nursing home services and community based services in every county.*
- *Savings or unspent appropriations resulting from beneficiaries choosing less expensive home and community based services over nursing home care have not been reinvested in the long term care system.*

- *Vermont law requires any renewal of the waiver have as a term and condition that savings under the waiver be reinvested in long term care services. We are unaware of any effort on the state's part to request/include this reinvestment requirement as a new term and condition.*

*Suggestions for cost savings:*

- *Look at additional PERS service providers.*
- *Pro-rate companion/respite hours for clients who come on in the middle of the calendar year.*
- *Encourage more use of consumer and surrogate directed care.*
- *Allow the use of non-medical provider agencies.*
- *Change all of Choices for Care to a Flexible Choices model, which includes case management. Eliminate conflict of interest by having AAAs do all the case management.*

The DAIL Advisory Board took the above comments into consideration when it completed its work in October, 2009. Below is a summary highlight of the Board's discussion, conclusions and future directions:

1. Develop an additional HCBS option, Adult Family Care, which would include benefits for some individuals who require more intensive supports.
2. Develop a "flexible choice" option for the Moderate Needs Groups to improve access and consumer control.
3. Continue to examine the feasibility of establishing a system of case rates. In the near term, consider changes that will give some more flexibility to consumers, while reducing workload for case managers and state staff.
4. Proceed with the discussion of the following previously discussed items –
  - a. Potential of adding additional agency providers of personal care, respite and companion services
  - b. Expand Enhanced Residential Care capacity
  - c. Integrate evidence based practices for people with chronic conditions
  - d. Examine the feasibility of communal/shared living – aka "communes".