



Long-term Care **Vermont's Approach**

Individual Supports Unit
Division of Disability and Aging Services
Department of Disabilities, Aging &
Independent Living

National Medicaid Congress




- **Historical Prospective**

Senator Jim Leddy , Chair, Health and Welfare Committee, (D) Vermont Senate, South Burlington, Vermont

- **Choices for Care Overview** *Lorraine Wargo, Director, Individual Supports Unit*


Agenda

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- History
 - Overview
 - Implementation
 - Data
 - Trends
 - Next Steps
 - Questions

History

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- Legislative Action
 - Act 160
 - Other Initiatives


Overview

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- “Vermont’s 1st in the Nation 1115 Medicaid Waiver offers equal choice among all long-term settings – nursing home, home-based services, or enhanced residential care”.

Goals

- Provide choice and equal access to long-term care services and supports.
- Serve more people.
- Create a balanced system of long-term care by increasing the capacity of the home and community-based system, while maintaining the right number of quality nursing facility beds.
- Manage the costs of long-term care.
- Prepare for future population growth.

Overview

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- Each individual's needs are evaluated based on a clinical assessment and determined to be “highest”, “high”, or moderate needs.
 - Highest needs individuals are enrolled once Medicaid financial criteria have been determined.
 - High needs individuals are enrolled when funds are available, and financial criteria has been determined. Enrollment consideration is given to individuals with special circumstances.
 - Moderate needs services are designed to be preventative in nature; services are adult day, homemaker, case management.
 - 3 levels of need – “highest”, “high” and “moderate”.




HISTORY

“Never Say Never”



Eligibility

- 
- Vermont resident
 - 65 years of age or older OR 18 or older with a physical disability
 - Meet financial criteria for Vermont Long-term Care Medicaid
 - Meet specific clinical criteria

Options

- Home-Based
- Enhanced Residential Care
- Nursing Home



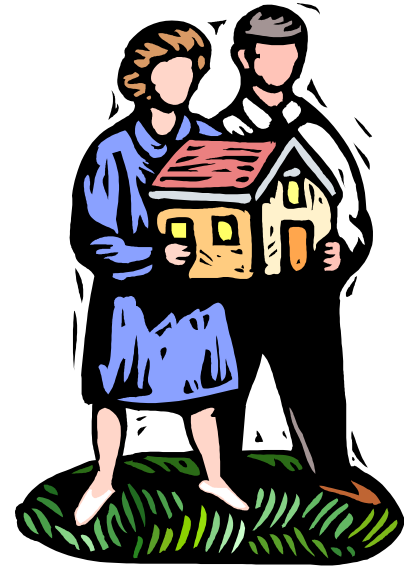
Home-Based

- Case Management
- Personal Care
- Adult Day
- Respite
- Companionship
- Assistive Devices and Home Modifications
- Personal Emergency Response Systems



Enhanced Residential Care

- Personal Care
 - Meals
 - Medication Management
 - Nursing Overview
 - Activities
 - 24-hour Supervision
 - Laundry/Housekeeping



Nursing Home


- Personal Care
- Meals/Nutritional Services
- 24-hour Skilled Nursing
- Rehab and Therapy
- Activities
- 24-hour Supervision
- Social Services
- Laundry/Housekeeping



Implementation

- Approval received from Centers for Medicare & Medicaid Services (CMS) June 2005.
- July-August 2005 hired 12 regionally-based Long-Term Care Clinical Coordinators; these staff determine clinical eligibility, provide technical assistance to providers; provide options education for consumers; conduct utilization reviews; and facilitate waiver teams.
- CMS conducted successful readiness review on site in September; approved implementation for October 1, 2005.
- Medicaid regulations approved effective October 7, 2005.
- October 1, 2005 – 3,447 participants were transferred from the old program to the new Choices for Care Program.

Implementation

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- Since October 1, Long-Term Care Clinical Coordinators have determined clinical eligibility for over 2,100 individuals seeking or receiving Choices for Care Services.
 - Providers received initial training through Vermont Interactive Television sessions; waiver team meetings; and individual contacts.
 - Billing and reporting processes were designed and implemented with Electronic Data Systems (EDS).
 - Waiver recipients received notification of enrollment via individual letters; case managers from local providers and state staff provided technical assistance to individuals with questions and concerns.
 - Long Term Care Ombudsman contract was negotiated and implemented, expanding services to home-based recipients.

Implementation



- **Nursing Homes**


- Initial concerns regarding payments for admissions.
- Hospital discharge planners concerned that nursing homes wouldn't admit individuals.
- DAIL staff met with nursing home administrators and hospital discharge planners; issued clarifying memorandum.
- New procedures regarding “patient share” added some confusion and required additional clarification with providers.

Implementation

- Home-Based Services

- Some role confusion between DAIL's new Long-Term Care Clinical Coordinators and community provider case managers.
- Ongoing waiver team meetings, VIT sessions, provider meetings and support from DAIL staff have assisted with clarifying roles & expectations.
- Billing issues developed as a result of unintended consequences of new procedures (e.g. patient share)
- Weekly meetings with EDS, Department for Children & Families (DCF) and Office of Vermont Health Access (OVHA) have resolved many of these issues.

Implementation

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- **Enhanced Residential Care Homes**
 - Overall smoother transition to Choices for Care.
 - Initial data indicate higher use of ERC homes.
 - New billing procedures created some confusion and delays in payment.
 - Weekly meetings as noted previously with EDS, DCF, & OVHA have resolved many of the issues.


Implementation



- **Adult Day Providers**

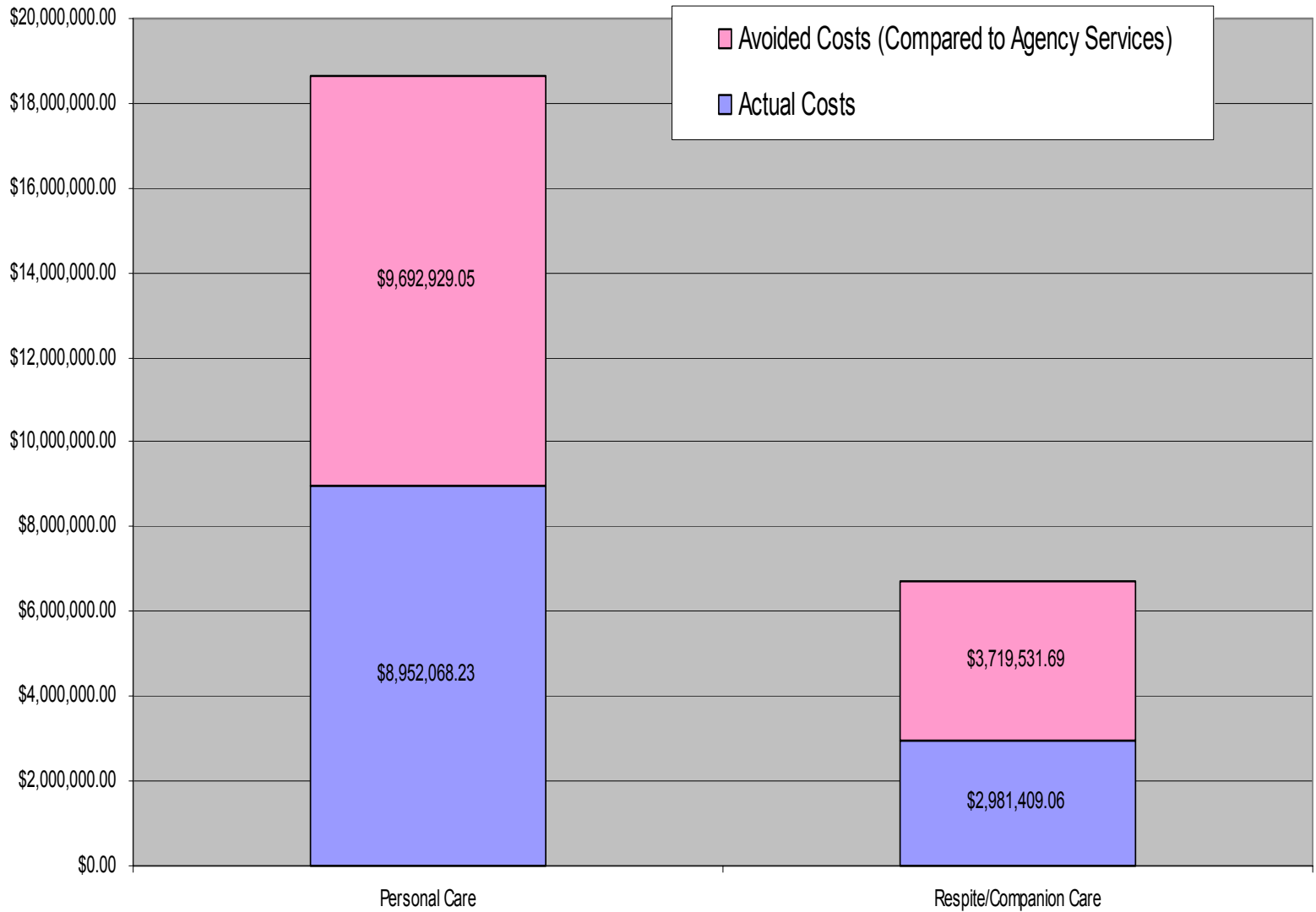
- Negotiations during regulatory process resulted in changes to financial eligibility for moderate needs group not intended during program design.
- As a result, individuals previously expected to be eligible, were not, creating confusion for providers & consumers.
- Implemented exception to the rule allowing those Vermonters to qualify and reinstate adult day services.
- New billing procedures presented significant issues for adult day providers.
- Weekly meetings, teleconferences, meetings with adult day providers, etc., have resulted in resolution or planned resolution of many of these issues.

Implementation

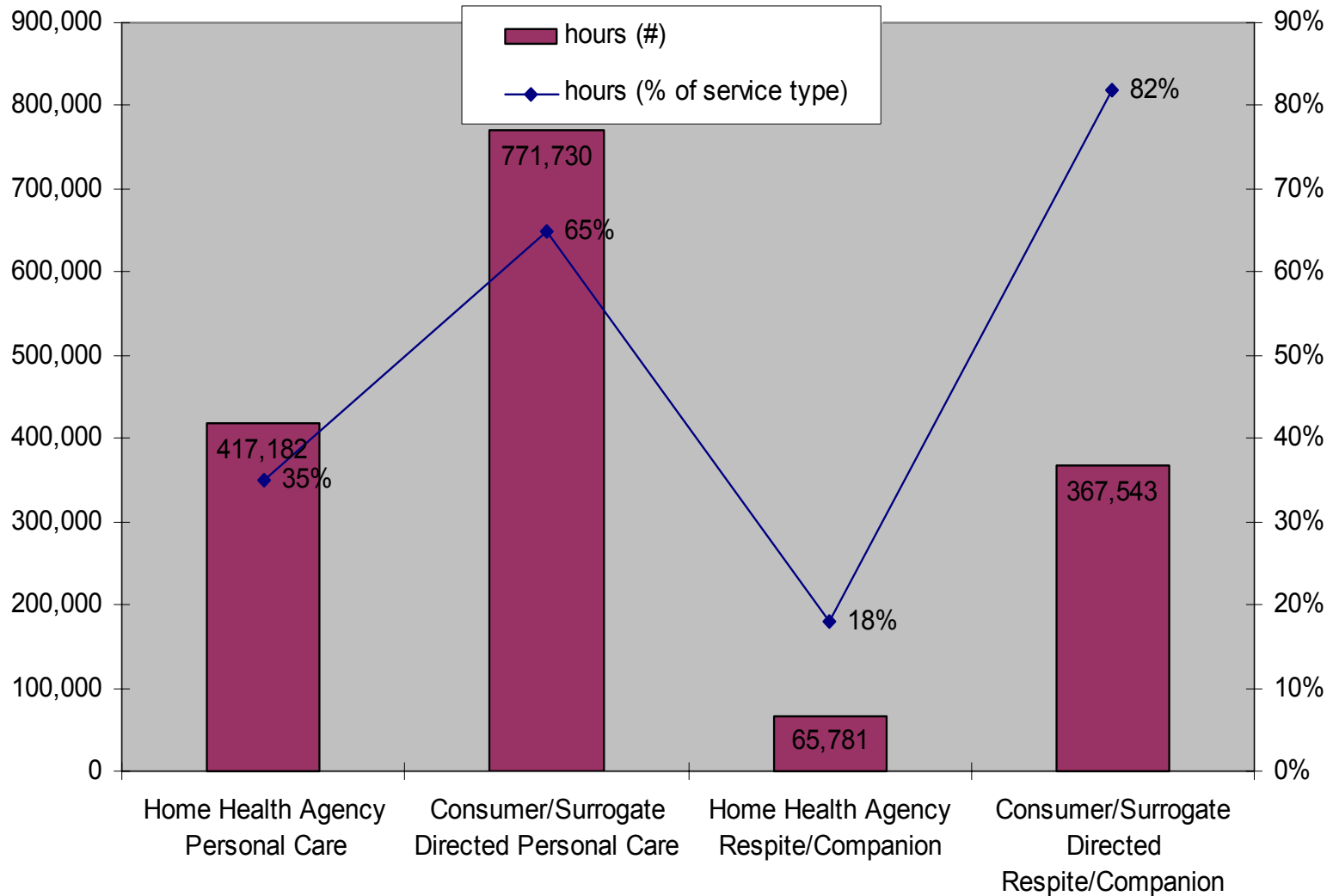
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- Volume of data into the new database system created delays in data entry.
 - Initially, the volume of applications from all settings resulted in delays in processing clinical applications.
 - Revisions to Choices for Care Regulations will be required to adjust the financial eligibility section for “moderate needs” individuals.
 - Financial eligibility issues continue to be a work in progress.
 - Previous wait list decreased from 260 to current CFC high needs wait list of 55.



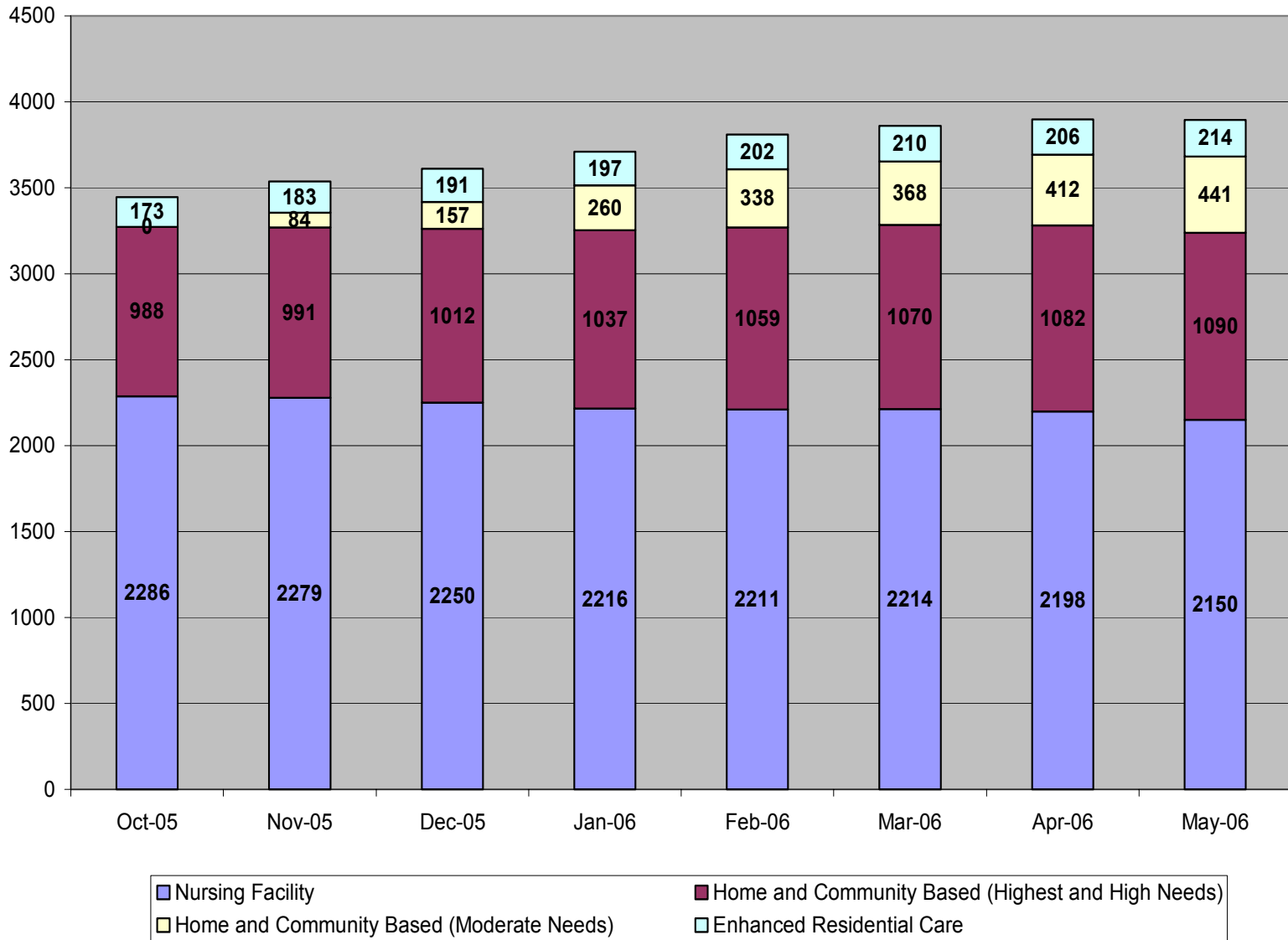
**Consumer and Surrogate Directed Care:
Actual Costs and Avoided Costs, July 2005-April 2006**



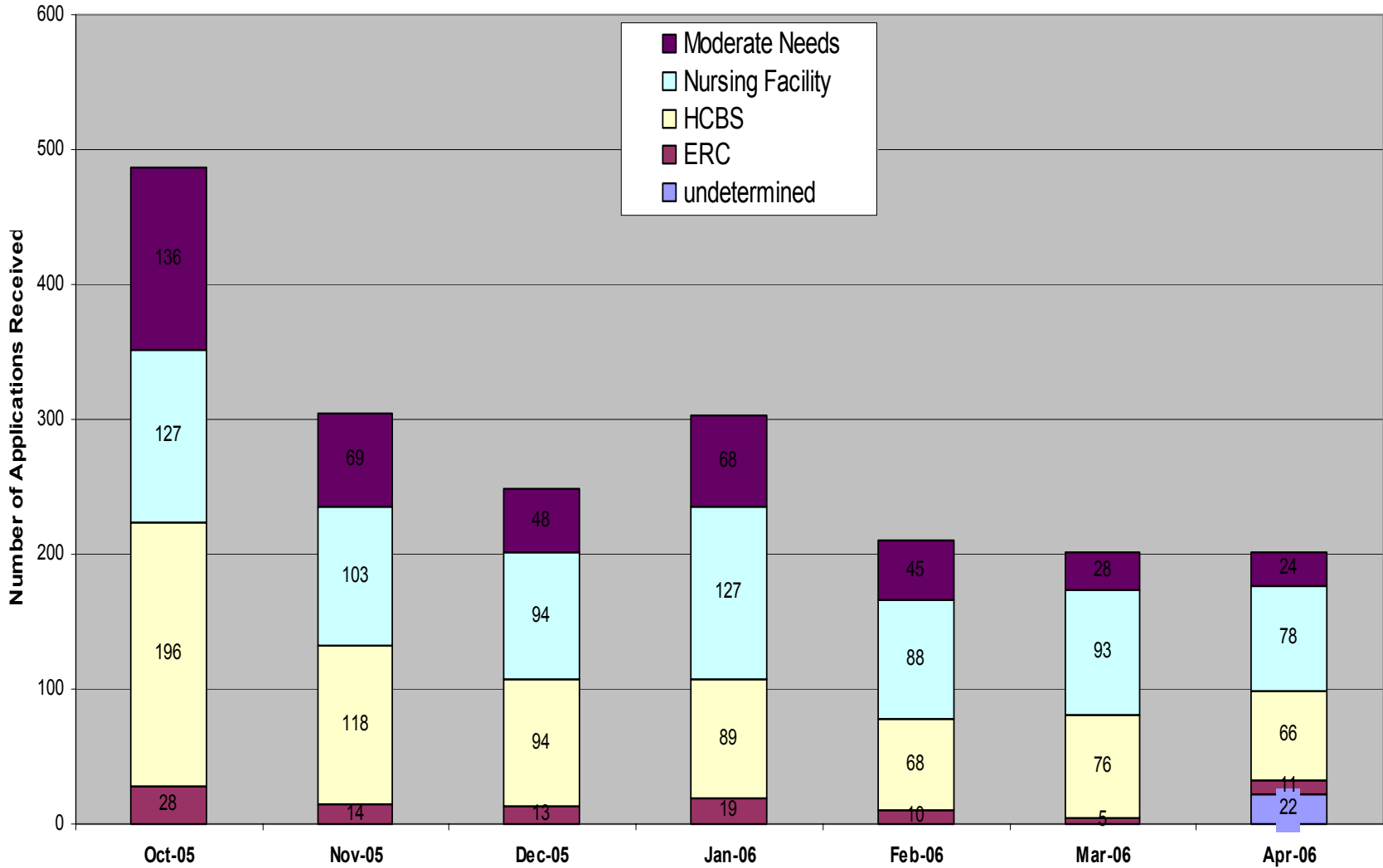
Waiver In-Home Services by Type, July 2005-April 2006



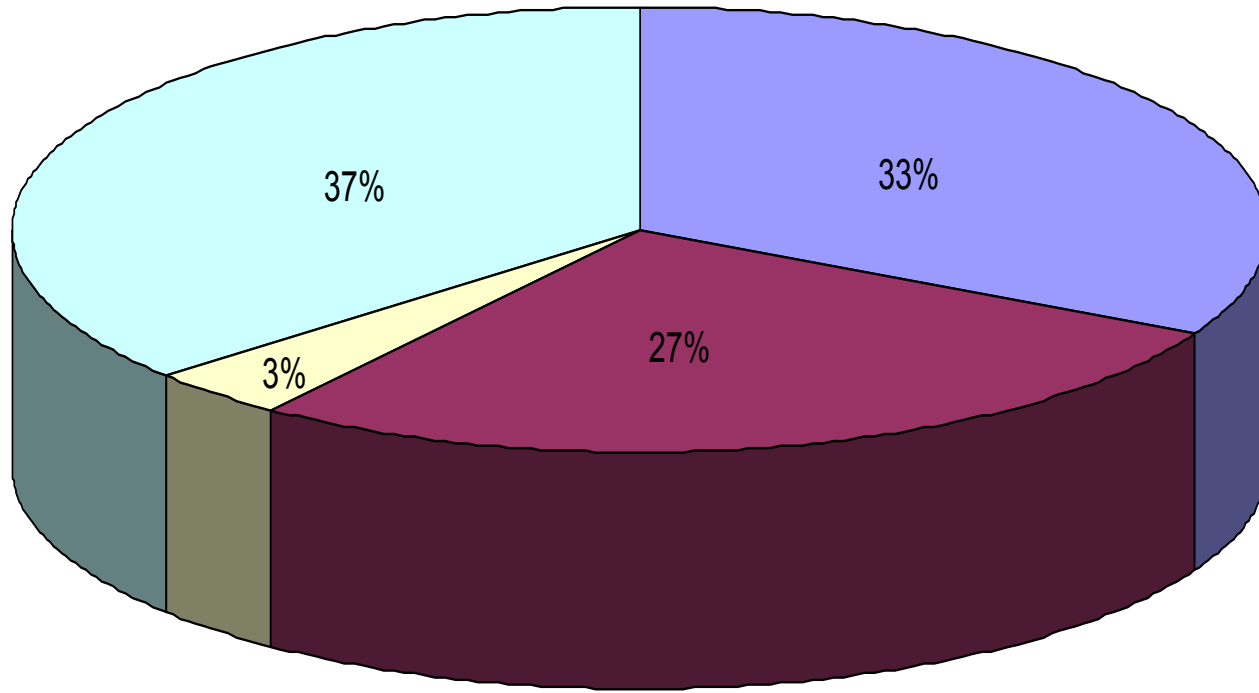
Choices for Care: Total Number of Enrolled Participants October 2005 - May 2006



Choices for Care Applications Received by Month, by Service Program
October, 2005 - April, 2006

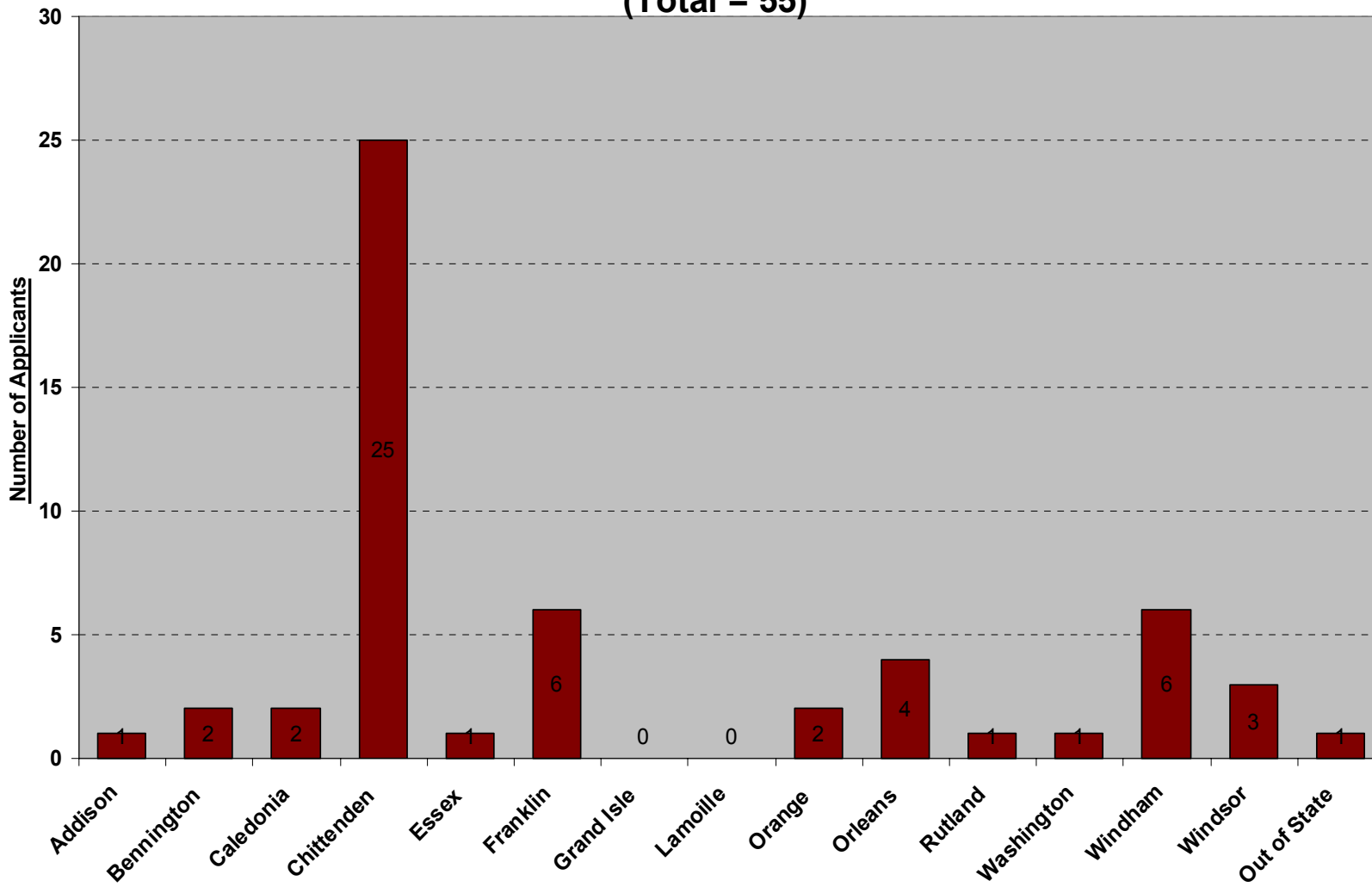


Consumers Pending Long Term Care Medicaid Eligibility Per Department of Children & Families

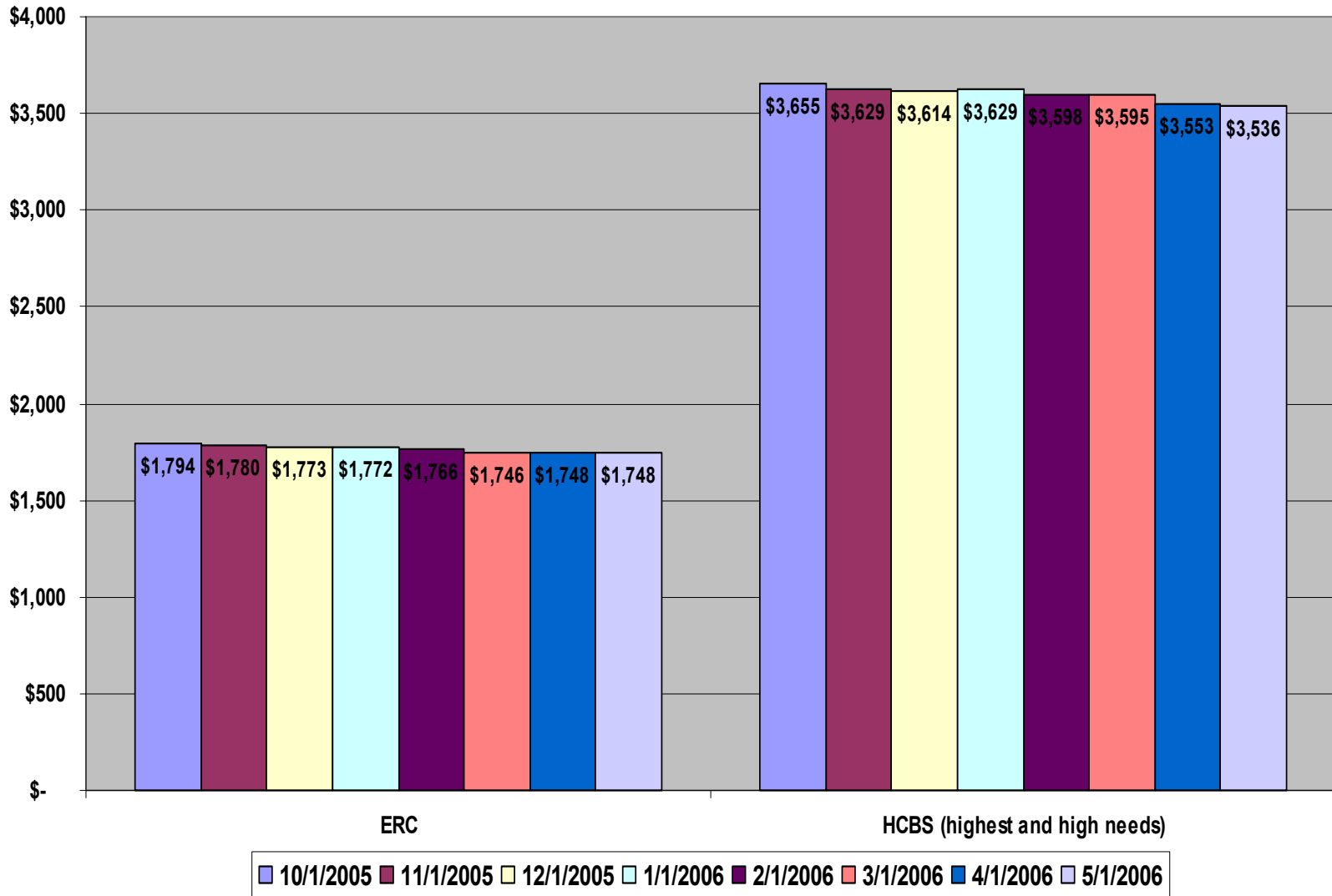


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| ■ No Application on File | ■ Applications Granted |
| ■ Applications Denied | ■ Applications Pending |

Choices for Care: High Needs Waiting Lists by County as of 5/1/06 (Total = 55)




Choices for Care: Average Monthly Costs of Approved Plans of Care
October, 2005 - May, 2006




Goals

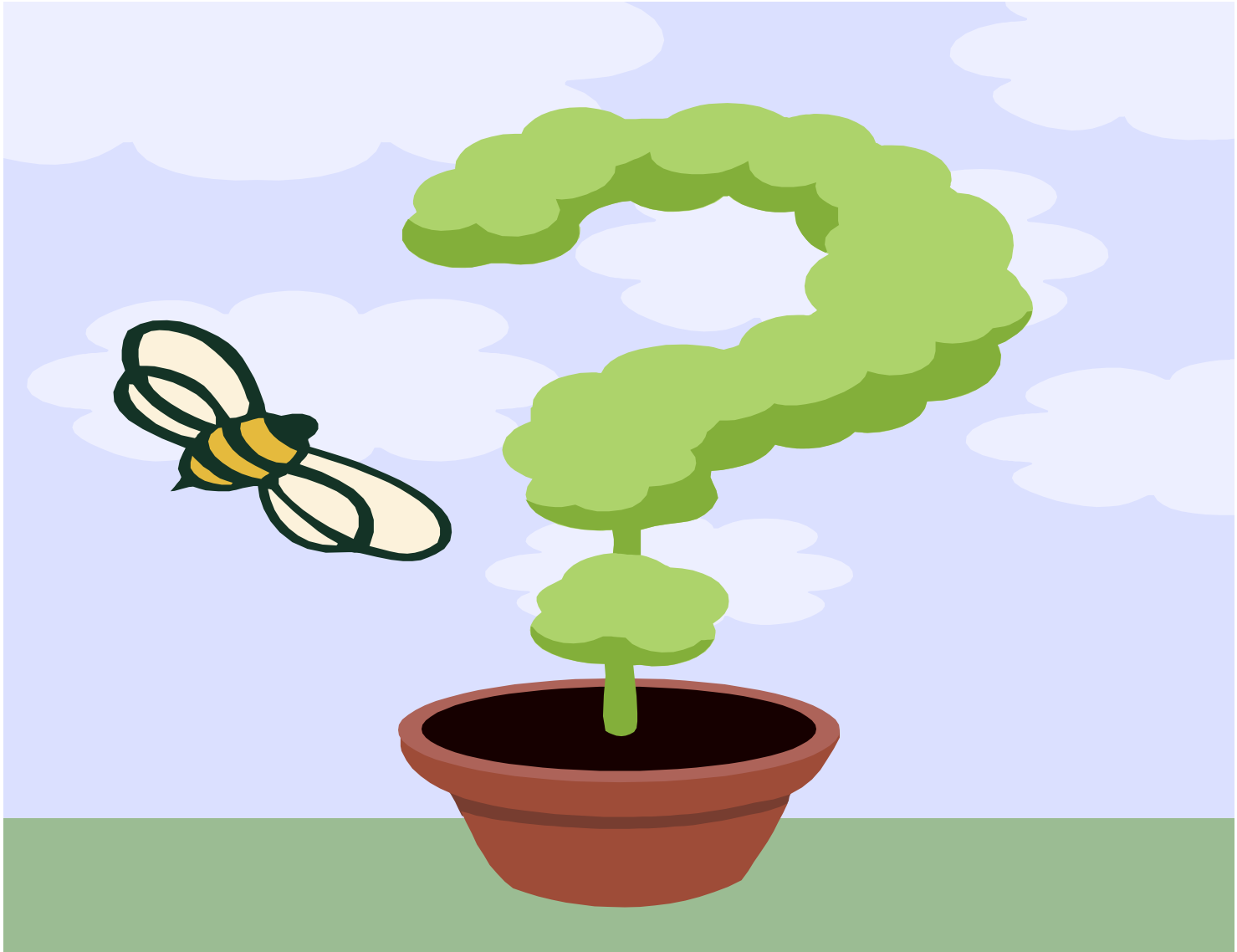
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Early Trends

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- Decrease in nursing home admissions.
 - More individuals receiving services.
 - Decreased Waiting list.
 - Increase in home-based and Enhanced Residential Care admissions.
 - Decreasing cost in Plans of Care.

Next Steps

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- Flexible Choices
 - Paying Spouses
 - Programs for All-inclusive Care for the Elderly (PACE)
 - Health and Long-Term Care Integration Project



Thank You!

