

Testimony of Lila Richardson, Vermont Legal Aid
Joint Fiscal Committee
August 18, 2009

I am testifying on behalf of Vermont Legal Aid in opposition to the Administration's plan to use the FY 2009 "carry forward" of \$731,372 for the Choices for Care Program to reduce the FY 2010 deficit. Act 56 (2005) requires that savings under the Choices for Care plan should be reinvested in home and community based services for Vermonters in need of long term care services. The failure to reinvest the 2009 General Fund amount results in a total loss to the Choices for Care program of \$2,434,660 due to the loss of matching federal funds.

We are concerned about this plan for several reasons:

Act 56 of 2005 clearly states that any Choices for Care savings "shall be retained by the department and reinvested into providing home-and community based services under the waiver." The administration suggested in testimony that the legislature would have to "notwithstanding" this provision in order to apply the carry forward funds to deficit reduction. Obviously any such action would represent a significant policy change.

The administration's summary of the effects of this use of the carry forward money indicated that the proposed use of the carry forward money will not result in any programmatic changes in Choices for Care. However, failure to use the money for Choices for Care services will create increasing pressures on the overall waiver and in particular on the system for home and community based care.

There are currently approximately 76 people on the high needs waiting list. People only qualify for this waiting list if they meet a clinical level of care test which would have guaranteed coverage in a nursing home prior to the Choices for Care waiver. The waiver created a "high needs" group that would no longer be entitled to long term care services in order to manage the program if funding was not sufficient for all individuals. Since February 2008 the waiting list has been growing, and there is no plan to fund the waiver to a level that would reduce or eliminate the waiting list. Several pages from the April 2009 quarterly report with information about the high needs list are attached.

People now stay on this high needs waiting list until they decline to the point where they meet the highest needs criteria or they can show that they need services immediately due to exceptional circumstances. The waiting list has become a permanent part of the waiver. The loss of \$2.4 million guarantees that this list will grow and more people will be denied access to needed services.

In addition to funding services for some of the people on the high needs list, the \$2.4 million could be used for other investments in home and community based services for Choices for Care. Care giver salaries could be increased. (These were cut by 2% as part of the provider cuts in the budget and were inadequate before that cut.) Investments could also be made in fragile parts of the system such as residential care home and adult day reimbursement.



Choices for Care

Quarterly Data Report

April 2009

This report describes the status and progress of Choices for Care, Vermont's Medicaid long term care service system. This report is intended to provide useful information regarding enrollment, service, and expenditure trends.

The primary data sources are SAMS Choices for Care enrollment and service authorization data maintained by the Division of Disability and Aging Services, Medicaid claims data maintained by EDS, and resident days of service submitted by Vermont nursing homes to the Division of Rate Setting.

We welcome your comments, questions and suggestions.

For additional information, or to obtain copies of this report in other formats, please contact:

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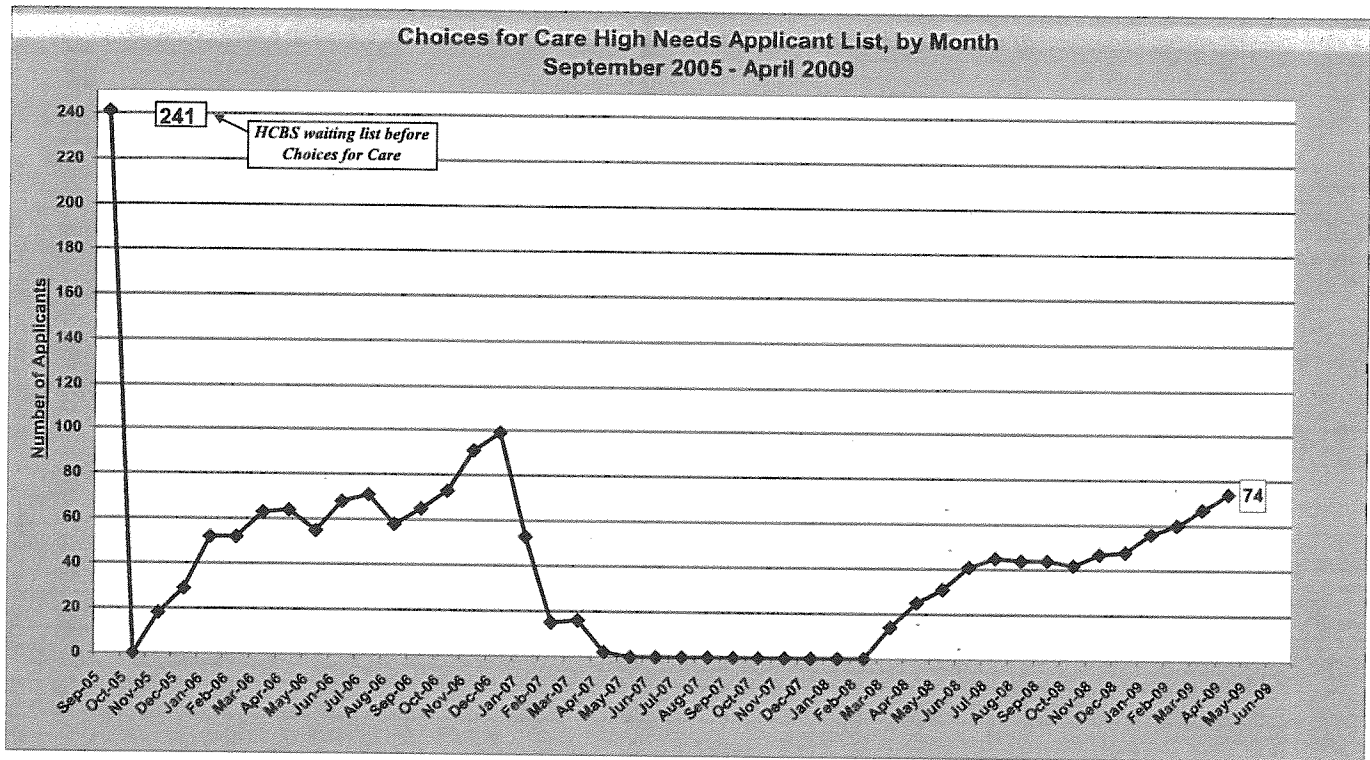
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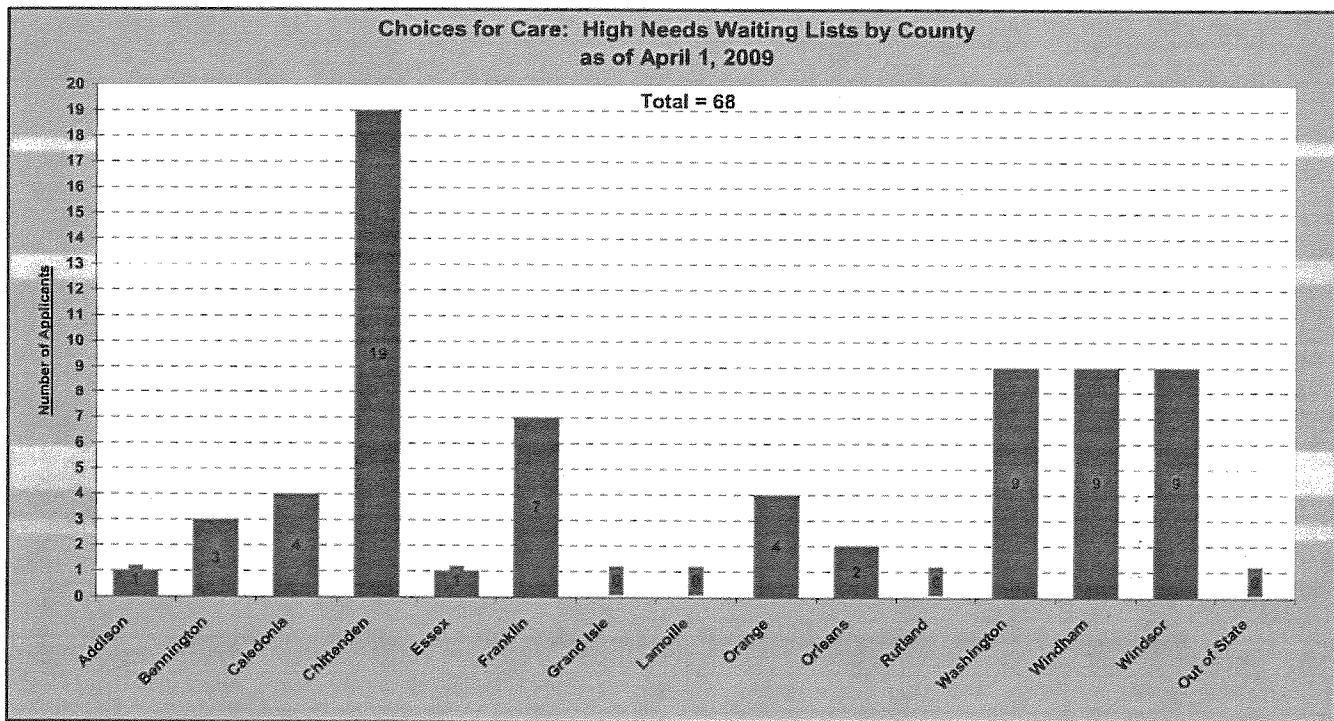
Data source: DAIL/DDAS SAMS database.

Another indicator of access to home and community based services is the number of people on waiting lists. Prior to Choices for Care, many applicants for HBS and ERC were placed on waiting lists. The total number of people on waiting lists fell when Choices for Care was implemented in October 2005, when all applicants who meet Highest Needs Group eligibility criteria became entitled to the service of their choice.

The High Needs Group was created as a financial ‘safety valve’ in the Choices for Care expanded entitlement to HBS and ERC, allowing DAIL to create a waiting list when expenditure projections exceed the budget. Note that the Choices for Care waiting list is unique in that it affects people applying for all settings, including nursing homes. In other states, waiting lists are imposed for HCBS but not for nursing home services.

In October 2005, all applicants who met the High Needs Group eligibility criteria were placed on a waiting list. The number of people on this waiting list slowly increased over time. Based on the availability of funds, small numbers of people from the waiting list were enrolled in Choices for Care during July 2006 and December 2006. In January 2007, in the context of positive expenditure trends the legislature directed DAIL to enroll all High Needs Group applicants, and the waiting list fell to zero.

Due to financial pressures, the High Needs Group waiting list was recreated in February 2008. The current economic climate suggests that this waiting list will continue for the foreseeable future.



Data source: DAIL/DDAS SAMS database.

This graph shows the distribution of the High Needs Group waiting list by county. The waiting lists in Chittenden, Windham and Windsor counties are disproportionately large. The waiting lists in Addison, Lamoille, and Rutland are disproportionately low. This may reflect regional differences in the intended use of Choices for Care and/or differences in access to other services as alternatives to Choices for Care.

Because people's needs change, it is important that case managers monitor the status and circumstances of people who are on the waiting lists. Case managers also help to identify those people who should be served under special circumstances, or people whose needs have changed such that they meet the eligibility criteria for the Highest Needs Group.

Other aspects of the waiting list data are of interest. During the period July 2007- January 2008, nearly 500 people were enrolled into the CFC High Needs Group. This represents about 70 people each month, or a total of about 840 people annually.

Since the waiting list was created in February 2008, it has grown very slowly. Few people have been enrolled under special circumstances each month. What happened to the hundreds of people in the High Needs Group who would have been expected to apply, but did not? There are several explanations:

1. Some people rely on unpaid caregivers...family, friends, and neighbors. Across the United States, this is the most common solution. AARP estimates that unpaid family caregivers provide about 80 percent of the assistance provided to people who need help with daily activities. (<http://www.aarp.org/research/housing-mobility/caregiving/aresearch-import-779-FS91.html>)
2. Some people use alternative services: home health services, area agency on aging services, residential care homes, adult day services, etc.
3. Some people are served through the Moderate Needs Group.
4. Some people simply 'make do', getting by with little or no assistance, as before.