

**Rebalancing Long-Term Care Systems in Vermont:
State Case Study as of December 2007**

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The overall Rebalancing Research is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. Rosalie A. Kane is the principal investigator from the University of Minnesota and Elizabeth Williams is the CNAC project director. This final case study for the State of Vermont covers a period through December 2007. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the current Vermont Liaison to the study, Joan Senecal, Commissioner, Vermont Division of Aging and Independent Living.

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Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems, six crosscutting topic papers on issues in rebalancing, and a series of 5 Chartbooks presenting quantitative analyses of Medicaid expenditures for consumers in HCBS versus nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. A list of these products with web links for completed documents is provided in the Appendix.

For the final case studies—in this instance for the State of Vermont, we concentrated on the perspective of State officials on accomplishments in rebalancing their long-term support systems for all clientele, and the future directions for the State. We also updated particular strategies that we had highlighted in the 2005 case study and the 2006 Updates. The report is based on comprehensive review of web and print materials, a site visit by Robert Mollica and Rosalie Kane on November 29th and November 30, 2007 and telephone interviews as needed before and after the site visits.

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Executive Summary

Vermont is characterized by a strong commitment to expanding community care for all populations receiving long-term support under Medicaid, and to person-centered and consumer-directed models of service delivery. In the 3 years since the baseline case study, Vermont has continued to make progress toward a balanced system by offering consumers choices from an array of services and settings. Progress towards a rebalanced service system has been hastened by establishment of specific numerical goals for reducing reliance on nursing homes, an organizational structure at the state level that removes barriers across target populations, and unique and closely watched 115 waiver program, Choices for Care.

This case study highlights the following:

- The Choices for Care program, a five year §1115 demonstration program serving older adults and individuals with physical disabilities creates an entitlement to home and community based services for individuals who meet the program's "highest needs" criteria. Individuals who meet the "high needs" criteria are served as funds are available. Choices for Care will test the preventive impact of a limited service package for individuals with "moderate needs" who do not meet the nursing facility level of care criteria. Since Choices for Care was implemented in October 2005, the number of individuals receiving home and community based services increased by 50% and the number of individuals served in nursing facilities declined by 11%. Waiting lists for 1915 (c) waiver services were eliminated for elders and adults with physical disabilities.
- The Global Commitment to Health project, a second §1115 Demonstration Program approved by CMS in 2005, which covers Medicaid acute care services for all populations and long term care services for individuals with developmental disabilities and traumatic brain injuries. This program is still under development.
- The State's exemplary community services in the developmental disability area In 2005 Vermont stood out because of its elimination of and its one-on-one model of community residential settings for institutions for individuals with developmental disabilities. .
- Consolidation of state agencies. State officials reported that combining in one department aging and disability and developmental disability programs and staff has changed the culture of the Department of Disabilities, Aging and Independent Living (DAIL) and brought more options to older people. For example, models developed for individuals with developmental disabilities, such as the shared living housing model which provides 24 hour supports, are now being extended to serve elderly people, including those with mental health and behavioral needs. In a small pilot, providers were recruited by Developmental Service Agencies that serve as the single entry point for individuals with developmental disabilities.

- Anticipated next steps, including implementing the integrated acute and long-term care program, developing more housing options, and working on mental health issues.

Rebalancing Long-Term Care Systems in Vermont: State Case Study as of December 2007

Introduction

Background

Vermont is the least populous State in the Rebalancing Research Project, and it occupies the smallest land mass. Despite this scale, it is characterized by strong involvement and participation at the county and township levels. The State has a strong commitment to developing a range of community services, and situating them in local communities where Vermonters live. Vermont was selected to participate in the Rebalancing Research Project as an example of a small state with a tradition of local involvement; marked success in achieving deinstitutionalization for persons with Mental Retardation/Developmental Disabilities (MR/DD), which was achieved prior to the beginning of our study; and a planning process underway for achieving rebalancing towards greater community care and enhanced consumer direction for all other populations needing long-term supports.

Vermont reorganized its State agencies for long-term supportive services (LTSS) in a renamed agency the Department of Aging and Independent Living (DAIL). DAIL has responsibility for a full range of HCBS and institutional services for all populations. At the time of the baseline study, Vermont has acquired its innovative and closely watched 1115 waiver to implement Choices for Community Care (CCC), an initiative that uncoupled community care from nursing home care by creating an entitlement for the later_community as well as for nursing home care for a subset of clientele with highest needs while expanding care to other groups of clients with high or moderate needs. To implement, Vermont revised its system for access to services. At the request of the legislature and in conjunction with implementing Community Choices, the State also was requested to report on the future of the nursing home in Vermont.

Summary of Earlier Rebalancing Case Studies

Management strategies in Vermont that have been tracked in the Rebalancing Project include: the above mentioned Community Choices program; the Global Commitment to Health demonstration integrating acute-care and long-term supports; and the above-mentioned reorganization of state agencies for LTSS that integrated MR/DD programs with all other aging and disability programs. A short and long baseline case study on rebalancing in Vermont was released in 2005 and an update of activities in Vermont between July 2006 and July 2007 was part of a report released in April 2007.¹

State Initiatives

Update on previously identified state initiatives

Choices for Care. The “Choices for Care” demonstration was implemented in October 2005. Choices for Care is a §1115 Demonstration Program serving older adults and adults with physical disabilities that creates three service groups based on functional and medical conditions – highest needs, high needs and moderate needs. The operational protocol states that “services will be provided on an entitlement basis to both those in the Highest Need group and in the High Need Group; however, those in the High Need group may have to wait to receive services until funds are available. In the interim, they may receive community Medicaid services, if they are eligible, and any other service for which they may qualify.”² Individuals who meet the

¹ Links to the short case study *Rebalancing Long-Term Care Systems in Vermont: Experience up to July 31st, 2005* and to the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States*, July 2005 to July 2006 are on the CMS New Freedom website, last visited on April 8, 2008 at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage. A long baseline case study on Vermont is on the website of the Long-Term Care Resource Center at University of Minnesota, at http://www.hpm.umn.edu/lcresourcecenter/on_going_research/Rebalancing_state_ltc_systems_case_studies.htm.

² Choices for Care Operational Protocol. Available at: <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-documents/cfc-1115-oprational-protocol>. See Section A and appendix D.

“moderate needs” criteria, which are lower than the nursing facility level of care criteria, are eligible for a limited benefit package (homemaker, adult day care and case management).

Legislation approving Choices for Care directed that any savings realized by the demonstration be retained by DAIL and reinvested to expand home and community based services under the demonstration. If Choices for Care is renewed after five years, the waiver application must include a provision that any savings be reinvested. This commitment to building the infrastructure and service array continues strategies adopted in 1996 under Act 160. The law directed the Department on Aging and Disabilities (now DAIL, formerly DAD) to reduce nursing home spending in FY 1997 through FY 2000. Funds were shifted to pay for HCBS waiver services, the TBI waiver, the enhanced residential care homes waiver, attendant services program, homemaker services program, Older Americans Act services, adult day care and the Vermont Independence Fund.

The services available under Choices for Care have been expanded. Spouses are now eligible providers of care in addition to other family members. “Flexible Choices,” a cash and counseling program, was implemented in July 2006 as an option in Choices for Care on a statewide basis with the goal of serving 50 elders or adults with disabilities in the first year and 250 by the project’s end. As of December 2007, 40 participants were enrolled and 33 were receiving services under their own budget. Participants may choose to enter one of two PACE programs; the Colchester PACE site became fully capitated in 2007 and the new Rutland site became fully capitated in February 2008; prior to that they operated as Pre-Pace programs.

Comprehensive Systems Transformation. DAIL received a Comprehensive Systems Transformation Grant from CMS in 2004 to develop MyCare Vermont, a voluntary, integrated

acute and long term care program that includes Medicaid and Medicare services. Planning for MyCare was based on five key concepts:

- Coordinate all care planning through a Person-Centered Interdisciplinary Care Team, comprised of the Participant, the Participant's primary care provider, a non-medical service coordinator, and a registered nurse;
- Facilitate communication and coordination through the use of a common Centralized Comprehensive Record;
- Provide far greater flexibility of covered services than is allowed under traditional Medicare or Medicaid through a capitated payment (a per person rate) to the entity operating the program;
- Integrate Medicare and Medicaid funding to eliminate existing perverse incentives and complexities for those who are eligible for both programs; and
- Produce program savings to reinvest in services for participating Vermonters.³

After an 18 month planning period, DAIL awarded planning grants in 2007 to conduct feasibility studies. One organization received separate grants to develop program options for adults with disabilities under age 65 and one for elders age 65 and older. A second competitive RFP will be issued to support the program's infrastructure.

The interdisciplinary care team is the core feature of the model. The Team will consist of the participant (or a designee selected by the Participant), a Primary Care Physician or Nurse Practitioner, Case Manager/Social Worker, and Registered Nurse. The team members will be employees of or staff under contract with the Organization. Other members may be added to an individual Participant's team, based on the Participant's condition and/or needs.⁴

Responsibilities are described for the Team and each member of the Team.

Contracting organizations will be expected to allow consumers to direct their care and to provide 'flexible services' that substitute for regular Medicaid State Plan and waiver services and that are appropriate to the consumer's needs. Flexible services must be "participant-specific,

³ Joan Haslett, MSA. Recommendations for MyCare Vermont. Vermont Health and Long Term Care Integration Project, Department of Disabilities, Aging and Independent Living. Available at: <http://ddas.vermont.gov/ddas-projects/hltcip/hltcip-concepts/hltcip-concepts-documents/mycare-recommendations>

⁴ Joan Haslett, MSA. Ibid.

culturally appropriate and are fiscally and professional accountable.” Providers will have to offer consumers the option to direct, or allow a surrogate to direct, three services – personal care, respite care and companion services. The interdisciplinary care team will certify whether the consumer or the surrogate is able to direct the services and act as the employer.

The project is expected to begin enrolling participants by the end of September, 2008.

New Initiatives

Global Commitment to Health. Vermont also revamped its Medicaid acute care coverage under the Global Commitment to Health, a §1115 demonstration that caps total Medicaid spending and allows the state greater flexibility in the design of the program. The program offers premium subsidies to insured Vermonter’s with income below 200% of the federal poverty level. The demonstration was designed to increase access to affordable coverage; improve access to primary care; improve health care delivery for individuals with chronic care needs; and contain health care costs. The program includes state plan personal care services and 1915 (c) waiver services for individuals with developmental disabilities and traumatic brain injuries, in addition to acute care coverage. The Agency for Human Services contracts with the Office of Vermont Health Access (OVHA), the Medicaid agency, to serve as a publicly sponsored managed care organization. An intergovernmental agreement between the single State agency and OVHA outlines their respective responsibilities under the demonstration.

Rebalancing Goals, Objectives and Accomplishments

Primary responsibility for Vermont’s long term services and supports programs is located in the Department of Disabilities, Aging and Independent Living (DAIL). DAILs’ mission is to “make Vermont the best state in which to grow old or live with a disability with dignity, respect

and independence.”⁵ DAIL annually prepares a report, Shaping the Future of Long Term Care and Independent Living,⁶ to guide decisions about potential demand and the service capacity that will be needed to meet Vermonters’ long-term care needs. The report analyzes demographic and disability trends by county, makes recommendations to meet emerging long term care needs and describe developments in the state’s long term care system. The report uses population growth, disability rates and historical trends in the use of various service settings and programs to project the number of individuals likely to use nursing facilities, residential care and assisted living, personal care and other home and community based services over a five and ten year horizon. . DAIL estimates that the supply of nursing facility beds should be reduced by 272 beds statewide by 2016 based on declining utilization, expansion of home and community based services and residential alternatives and changing population and disability rates.

Vermont’s commitment to its rebalancing goals is reflected in the Governor’s 2009 budget that not only sustains current programs, but infuses additional dollars in some key programs to enhance home and community-based services. The Governor recommends allocating \$10 million more for services to people with developmental disabilities, \$6 million more for our long-term Choices for Care Waiver, \$6 million more for Children and Adult Mental Health services, \$300,000 more for youth aging out of foster care, \$700,000 more for people with traumatic brain injury, \$700,000 more for the Family Infant and Toddler Program, \$1 million more for providers of children’s residential services, and \$2 million for new Early Periodic Screening Diagnostic and Treatment services.

⁵ DAIL. Quality Management Plan. April 18, 2007. Available at: <http://ddas.vermont.gov/ddas-policies/policies-gmu/policies-gmu-documents/qm-plan>.

⁶ Julie Wasserman, MPH. Shaping the Future of Long Term Care and Independent Living. DAIL. May 2007. Available at: <http://dail.vermont.gov/dail-publications/publications-annual-reports/shaping-the-future-2006-2016>.

In 2006, the Vermont Legislature directed DAIL to conduct a Long Term Care Sustainability Study. The Study group was comprised of 36 members representing consumers, advocates, providers, legislators and staff. The group was directed to “collaborate with nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers to develop a long-range plan to address the sustainability of the Vermont's long-term care system.” The Study asked for recommendations on the development of adequate home and community based services to support increased numbers of Vermonters receiving that type of care; and the use of indexing as an appropriate method of ensuring sustainable funding for home and community based services. The Long Term Care Sustainability Task Force⁷ adopted DAIL's vision statement and core principles that envision a system in which:

- Vermonters have more control over their long-term care services and support. They are empowered to make decisions and more options are available to them.
- Services continue to be locally based, so Vermonters will not have to travel far from home to get the services they prefer or need.
- More people are receiving the services they need in their own homes, rather than in nursing facilities.
- There are fewer institutional settings; however the remaining nursing facilities are financially stronger and provide residents with a more home-like setting.
- Consumers have access to a greater variety and quantity of residential options, so if they want to continue to live in their own homes, they have options to do so.
- Complete, accurate and unbiased information about long-term care services and supports is available and easy to access.
- Long-term care services are coordinated and integrated with acute and primary care so Vermonters experience flexible, consumer-centered and cost-efficient services.

⁷ Long Term Care System Sustainability Study. January 19, 2007. Department of Disabilities, Aging and Independent Living. Available at: <http://www.dail.vermont.gov/dail-publications/publications-legis-studies/ltc-system-sustainability-report-jan-2007>.

- Services such as adult day and a variety of respite options are available to support unpaid caregivers.
- Services are coordinated with other activities, such as employment, to help those who want to participate in and contribute to their community in a variety of ways.
- As home and community based services expand to meet consumer demand, the system as a whole remains financially sustainable.

The report described core principles that guide decision making:

- *Person-centered* – the individual will be at the core of all plans and services.
- *Respect* – Individuals, families, providers and staff will be treated with respect.
- *Independence* – The individual’s personal and economic independence will be promoted.
- *Choice* – Individuals will have options for services and supports.
- *Self – Determination* – Individuals will direct their own lives.
- *Living Well* – The individual’s services and supports will promote health and well-being.
- *Contributing to the Community* – Individuals are able to work, volunteer, and participate in local communities.
- *Flexibility* – Individual needs will guide our actions.
- *Effective and Efficient* – People’s needs will be met in a timely and cost effective way.
- *Collaboration* – Individuals will benefit from our partnerships with families, communities, providers and other federal, state and local organizations.

The report was completed in 2007 and recommended the following:

- Rates for Choices for Care providers should be adjusted by an annual inflationary factor. This would include people participating in the consumer- and surrogate-directed options. Nursing facilities are currently the only Choices for Care provider for whom there are statutory inflationary increases except for case management services. For SFY08, the recommended inflationary factor is 3.75%; an increase of \$613,745 in state funds.
- Review and increase funding to certain home and community-based providers. Some home and community based services providers have not received increases for several years.
- Explore strategies to right-size the nursing facility industry with the goal of maintaining an adequate number of resident beds to meet the projected need for the next 10 years and to support quality of care in nursing facilities.
- Strengthen, support, and invest in the development of housing with supportive services, through the construction of additional housing units and by bringing supportive services to current housing sites and naturally occurring retirement communities. Work with the public, non-profit and private housing industries and other appropriate parties to design a 10-year plan that will achieve this objective.

- Continue the efforts to ensure an adequate supply of well-trained and supported direct care workers by promoting culture change, supporting training, the development of a state-wide caregiver registry and publicly recognizing the importance and value of this career choice. The Direct Care Workforce Task Force will provide recommendations for accomplishing these goals in its final report in December 2007.
- Strengthen access to quality mental health services for elders and adults with disabilities.
- Continue to strengthen consumers' access to complete and unbiased information about long term care services by seeking ongoing funding to support development of and operation of the ADRCs.
- Research the costs, benefits and risks of various methods for bringing non-Medicaid revenues to meet long term care needs such as reverse mortgages and long term care insurance.

The Sustainability study reinforced Vermont's trend toward expanding HCBS services.

In 1997, about 12% of all public (state and federal) spending for elders and adults with disabilities supported home and community based services. The Commissioner of the predecessor agency set a goal to spend 30% of all public long term care funds on community care. Vermont has exceeded this goal and state officials estimate that in FY 2008, 38% of all public funds will be spent on home and community based services.

Over time the state's benchmark for Rebalancing has shifted from expenditures to the percentage of people served in the community. DAIL set a goal to serve 40% of all Medicaid long term care beneficiaries in home and community based settings rather than institutional settings. Progress is tracked by county. In 2007, twelve of the state's fourteen counties served 50% or more of all individuals receiving long term care services in community settings.

In fiscal year 2004, 57.7% of Medicaid long term care funds were spent on home and community based services compared to 54% in FY 2000.⁸ Vermont ranked 11th among all states

⁸ Brian Burwell, Kate Sredl, and Steve Eiken. Medicaid Long Term Care Expenditures in FY 2004. Thomson Medstat. May 11, 2004.

in the percentage of Medicaid funds spent on home and community based services for elders and adults with physical disabilities in FY 2004 at 32%, an increase from 14% in FY 2000.

Community spending for people with development disabilities rose from 97% in FY 2000 to 99% in FY 2004.

However, comparing current expenditures to earlier years in Vermont is problematic, and may misrepresent the state's progress. Vermont operates two Section 1115 Demonstration programs. Choice For Care provides all long term care services to elders and adults with physical disabilities. The Global Commitment to Health covers all Medicaid acute care services, state plan long term care services and home and community based waiver services to individuals with developmental disabilities and traumatic brain injuries. Thus, expenditure data on home and community based services for individuals with developmental disabilities and TBI are not reported separately to CMS. Moreover, Choices for Care expenditure data do not include Medicaid personal care and home health data, which were previously included in the balancing tables prepared by Thomson Healthcare.

Choices For Care has allowed more Vermonters to receive services in community settings (see figure 1). The number of Medicaid beneficiaries living in nursing facilities dropped by 11% and the number receiving services in community settings rose 50%. In addition, 901 individuals with moderate needs received services that were not served prior to the Demonstration.⁹ The percentage of consumers living in community settings increased from 37% in October 2005 to 46% in October 2007. If the current trends continue, a majority of participants will live in community settings within two years.

⁹ Bard Hill. Choice For Care: Quarterly Data Report – October 2007. DAIL Information and Data Unit. Available at: <http://ddas.vermont.gov/ddas-publications/publications-idu/publications-idu-documents/cfc-qtrly-report-final-oct-2007>.

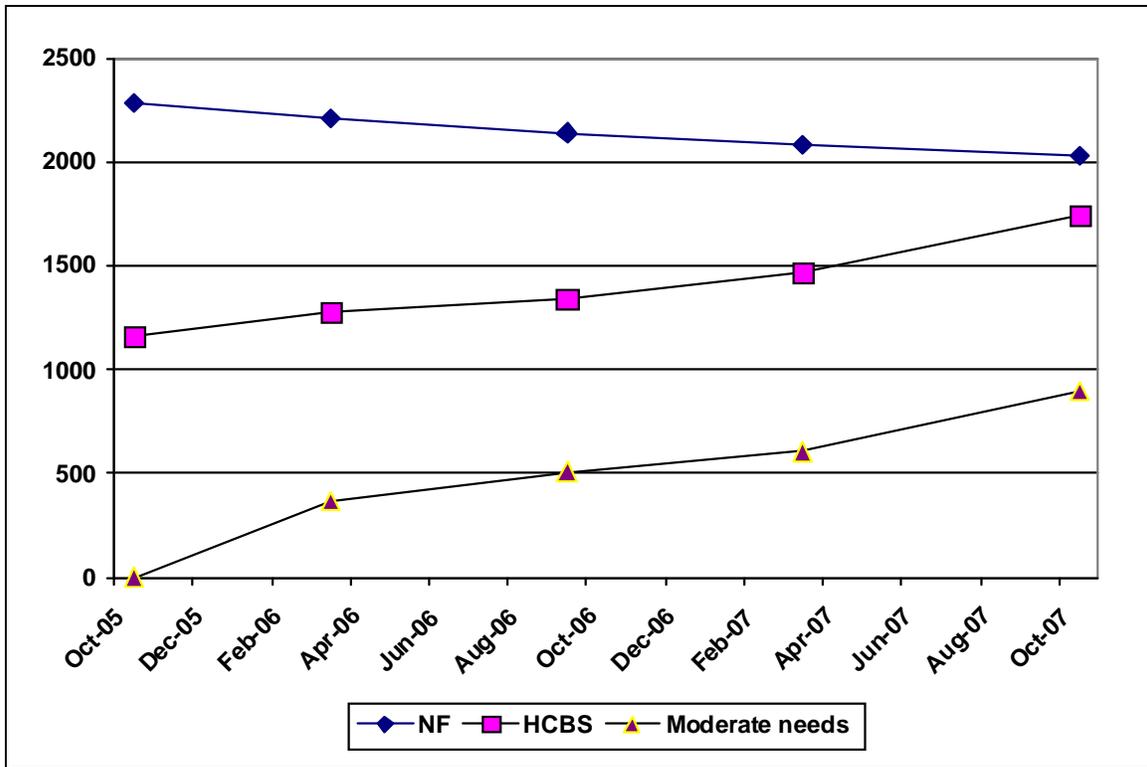


Figure 1: Trends in Enrolled Participants in Choices for Care, 10/05 – 10/07

State organization

Agencies responsible for long term care were consolidated in 2004; in fact the consolidation of the agency is one of the management strategies of interest in Vermont. The Department of Aging and Disabilities and the Division of Developmental Services merged to form the Department of Disabilities, Aging and Independent Living (DAIL) and is responsible for all long term care policy and services. Medicaid acute care services and financial eligibility are managed by other divisions of the umbrella agency (Agency for Human Services). Within DAIL, the Division of Disability and Aging Services is organized along functional lines rather than by program or population and was reported to operate very successfully. The Division is comprised of the Deputy Commissioner's Office and five support units. The Deputy

Commissioner's Office provides overall direction and leadership to the five major units and is responsible for budget development, legislative work, public information, interdepartmental relations policy and program directions. The five units include:

1. The Community Development Unit (CDU) works with local providers, consumer organizations, and other state agencies to facilitate the development of services and supports to meet the needs of people with disabilities and older Vermonters. The focus is primarily on building capacity within the broader community. Supports include older Vermonters and family care (Older Americans Act) services, adult day services, dementia respite, homemaker services, and residential alternatives.
2. The Individual Supports Unit (ISU) administers all Medicaid funded programs that provide individualized services to older Vermonters and people with disabilities. Supports include home and community-based waiver services (i.e., people with developmental disabilities, traumatic brain injuries, and older Vermonters), children and adult personal care/attendant services, high technology nursing, and other Medicaid services.
3. The Information and Data Unit (IDU) supports other DDAS units as a partner in the collection and use of data for program management, performance indicators, outcomes indicators, quality improvement, federally-required reporting and service planning.
4. Office of Public Guardian (OPG), acting under court authority, provides public guardianship where there is no friend or family member to serve as guardian, and the individual needs a public guardian to protect his or her rights or welfare.
5. Quality Management Unit (QMU) works in collaboration with the DDAS staff and service providers to improve and ensure the quality of services provided through DDAS.

Access

Choices for Care has increased access for many Vermonters. Financial eligibility workers are now co-located with DAIL registered nurses who complete the assessment and determine level of care. Monthly meetings are held to track and expedite applications. The quarterly data report for October 2007 states that over 90% of the Medicaid financial applications are processed within 12 weeks. Causes for delay include failure to submit the financial application, incomplete financial applications, excess resources that requires spend down, need for a disability determination, and applications that require review by legal staff.

Creation of a unified budget has also streamlined access. Funds for all Choices for Care services are appropriated in a single 'unified Budget' which allows funds to be allocated to home and community based services. Savings from the program have been sufficient to eliminate the waiting list for home and community based services. Financial data prepared by DAIL shows \$2.4 million in savings in FY 2006.

DAIL received an Aging and Disability Resource Center (ADRC) grant to promote access to information, referral and assistance for elders, adults with physical disabilities, individuals with developmental disabilities and individuals with or traumatic brain injury. The Area Agencies on Aging have traditionally provided information, referral and assistance to older Vermonters and their families. A toll-free Senior HelpLine automatically directs callers to their AAA. Prior to the ADRC project, information and assistance for non-elderly populations was not available systematically.

Consumer and key stakeholder input was sought to develop ADRCs. Partners included Area Agencies on Aging, the Vermont Center for Independent Living, the Office of Vermont

Health Access, the Department for Children and Families, Designated Agencies, Brain Injury Association of Vermont and Vermont 2-1-1.

The grant was designed to improve the information, referral and assistance system for older adults; design a streamlined eligibility process for Medicaid and Medicaid Long Term Care; and create a seamless link between the ADRCs and Medicaid eligibility determinations. All AAAs will use the same information, referral and assistance software and plans will be developed to market services to private pay consumers. Over time, adults with physical disabilities, individuals with traumatic brain injuries and individuals with developmental disabilities will be served.¹⁰

Service Array

All Medicaid home and community based services waiver programs for older adults and adults with physical disabilities have been replaced by the §1115 Demonstration Program. Choices for Care participants have access to a range of services, including case management, personal care, respite, personal emergency response, homemaker services, companion services, assistive devices, home modifications, adult day services and 24 hour individualized residential support services. Sixty five percent of the participants receiving personal care direct their care. Most recently, individuals may also elect to participate in Flexible Choices, a cash and counseling option; although Vermonters already can develop consumer-directed plans and can hire workers of their choice, including family members, Flexible Choices adds an additional option permitting the consumer to buy services and goods from an established budget if they prefer that option. The implementation of two PACE sites has also permitted an additional option

¹⁰ Long Term System Sustainability. Department of Disabilities, Aging and Independent Living. January 2007. Available at: <http://dail.vermont.gov/dail-publications/publications-default-page#legislative>

for consumers who live in the two areas where PACE is functioning. The array also includes enhanced residential care and nursing facility services.

In 2007, DAIL filled an identified gap in the array of services by developing 24 hour individualized services for participants who require 24 hour support such as individuals with dementia, mental health or behavioral issues. The service is based on the Shared Living model developed for individuals with developmental disabilities. Participants can receive services in their own home or apartment by a care provider, including a family member, or by moving to the home of the care provider. During the initial pilot phase of the service, providers were recruited by Developmental Service Agencies that offer a similar service to individuals with developmental disabilities. Care providers receive a rate based on the plan of care which is annualized and converted to a daily rate. Based on the initial success, DAIL prepared a policy statement and is developing standards that will include criteria for determining who is appropriate for the service.

Waivers serving individuals with developmental disabilities and traumatic brain injuries are included in the Global Commitment to Health Demonstration which also includes Medicaid acute care services and long term care state plan services. Supports for people with developmental disabilities are family supports, home supports, respite, service coordination, clinical interventions, community supports, crisis services and employment services. Supports for people with traumatic brain injuries include community supports (24 hour supervision), crisis supports, employment supports, environment and assistive technology supports, psychological and counseling services, rehabilitation supports, respite and special needs and case management.

DAIL is exploring ways to sustain and expand the delivery system. The Long Term Care Systems Sustainability Study used DAILs forecasting methodology to project the service

capacity that will be needed by 2015. The report noted that service capacity will need to increase in all counties but current reimbursement rates will make it difficult to reach the targets. Pursuant to the Legislature's direction, the Task Force examined options for indexing rates for home and community based services. Nursing facilities receive annual rate adjustments based on inflation and rebasing of cost factors. Home and community based services providers do not receive annual increases. The Task Force discussed the pros and cons of creating a cost-based reimbursement system for each home and community based (HCB) provider group. They identified the following issues:

- Each provider group would have to be able to provide reliable cost data on a regular basis to AHS which may pose a hardship for many small providers that do not have accounting systems set up to capture and report these data.
- AHS would have to create computer systems and increase staff to review and audit cost reports from 110 residential care homes, 14 adult day programs, five Area Agencies on Aging and 12 home health agencies, in addition to the 40 nursing facilities that already file annual cost reports.

Existing indices do use data from sectors that apply to home and community based service providers. Using an annual 4% increase in state funding for community programs, the Task Force projected that spending from state general revenues for all programs would increase from \$28.7 million in FY 2007 to \$40.8 million in 2016.

Quality Initiatives

Vermont received a Real Choice Systems Change Quality Assurance/Quality Improvement grant from CMS in 2004 to develop a comprehensive quality management system across all home and community-based waiver services. DAIL's Quality Management Unit (QMU) issued a Quality Management Plan in April 2007. The plan defines the processes for gathering information, remediation and improvement activities; describes indicators and

standards for measuring performance and contains a work plan for allocating resources. The plan is based on core values and outcomes that support person centered, respect, independence, choice, self-determination, living well, contributing to the community, flexibility, effectiveness and efficiency and collaboration.

DAIL also issued “Quality Services Resource Guide”¹¹ in 2007 to help consumers and family members know what to look for to get the best possible support from the agency. It provides information about quality and long term care services describes how DAIL assures and improves quality; and describes the consumer’s role in the quality assurance process.

In 2007, the QMU completed on-site reviews of all CFC providers. The discovery process included reviews and discussions with program participants, family members, agency staff and managers. Implementation of the Quality Management Plan began with reviews of services provided by several agencies throughout the State. These include services for people with physical disabilities, services for people with developmental disabilities, and for Vermont's aging population. Quality Services reports with required remedial activities were issued to several providers.

Consumers and family members participated in the development of and initial training sessions for the Quality Management Plan. Consumer and family feedback were obtained through structured interviews. Provider agencies must involve consumers and/or family members in corrective action activities. Consumer Quality Management Reviewer positions had been filled and these employees have contributed to the review process and hence, agency improvements. Staff in the Consumer Quality Management Reviewer position continues to

¹¹ Available at: <http://ddas.vermont.gov/ddas-publications/publications-qmu/publications-qmu-documents/quality-resource-guide>.

participate in training and is supported through a Team Leader and other Unit staff. This allows the individual to participate more fully.

Quality Management Unit staff received over 80 hours of training on the Quality Management Plan. A technical document on the QMP was prepared as a training tool and reference sources for reviewers. Staff are working with providers to carry out corrective action plans. These agencies have sought consumer and family involvement in developing, implementing, and evaluating their plans of correction. Quality Management Reviewers have been trained to provide technical assistance to service providers in involving consumers and family members in these processes.

State staff continues to develop a state-wide policy that addresses Critical Incident Reporting. Discussions with IT staff have begun. Other stakeholders, such as service providers, and the Division of Licensing and Protection are being included. Staff are reviewing existing databases as well databases developed in other states.

Housing

State officials described the continuing need to build and strengthen relationships between housing and service systems. Combining housing and services is a priority across programs and populations; the Agency for Human Services is forming a task force to develop a plan to address the housing and service gaps. The plan will address the needs of all populations that need long term care as well as poor families and people who are homeless or mentally ill. The task force was expected to be formed by the beginning of 2008.

The Long Term Care Sustainability report described the tendency for older Vermonters and adults with disabilities to move to congregate housing settings when it is difficult for them to remain in single family homes or apartments in the community. The report indicated that there are about 200

congregate housing settings and about half offer services to residents such as on-site resident service coordinators, activities coordinators, and live-in resident managers. Resident service coordinators are well informed about the programs and services that are available to residents. Resident managers live on-site and are typically responsible for keeping the building secure, addressing physical plant emergencies and calling for emergency help in the case of a medical emergency.

Vermont received an Integrating Supports with Housing grant from CMS in 2004. The grant objectives are to improve access by providing technical assistance to preserve or enhance existing housing or plan for future construction projects; develop, pilot and evaluate best practices to provide medication supports to residents in unlicensed housing; plan for co-location of 2 PACE sites in senior housing; develop strategies that support aging in place and prevent institutionalization; and provide training and education to housing and long term care stakeholders.

DAIL contracted with Cathedral Square Corporation (CSC), Vermont's leading provider of affordable housing for seniors to provide technical assistance to expand access to housing. During the course of the grant, CSC provided technical assistance services to ten affordable housing projects that contain a supportive services component for seniors and adults with disabilities. In addition, CSC provided technical assistance to three areas of Vermont that DAIL has identified as being under-served relative to those same housing projects with a services component. Technical assistance includes tenant surveys, site selection, feasibility studies, reviewing financing pro-formas and options, and assistance securing funding.

Cathedral Square Corporation (CSC) provided technical assistance to Brattleboro Housing Authority (BHA) to consider affordable housing with services options. The BHA elected to pursue housing with services project rather than a licensed assisted living facility and received a Community Development Block Grant planning grant. The funds were used for planning

activities (resident needs assessment, preliminary architectural feasibility and design work). The project did not proceed due to flood plain issues identified by the town. Despite the barrier, state officials noted some of the benefits from the activity. CSC continues to gain knowledge and expertise. The BHA and the Brattleboro community have a Resident Needs Assessment to guide future activities to address the affordable housing and services needs of elders. The process prompted the BHA to partner with DAIL and to convert a portion of an existing BHA elder project into licensed assisted living.

A multi-use site was completed by CSC that includes 63 units of affordable housing for elders and space for the United Way of Chittenden County, a VNA Adult Day Program site, HomeShare Vermont, and CSC's main offices, which provide a unique resource center for information and services for seniors and individuals with special needs. Three projects are still in the development phase. One would create group home-style housing to serve individuals with developmental disabilities who also have hearing impairments.

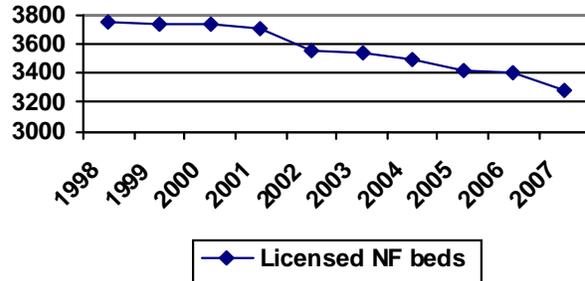
Another project is located in a rural area of Vermont known as the Northeast Kingdom. The Gilman Housing Trust owns and operates 83 apartments for elders and a 48 lot elder mobile home park in four communities that are located within a 20 minute drive from each other. CSC is providing development assistance to create 13 new affordable units and focal point for services to elders in a good part of the Northeast Kingdom.

Medication compliance was identified as a concern among older adults. The grant included development of a medication assistance program in elderly housing sites. The program plans to provide three levels of intervention – education and awareness and on-site reviews by local pharmacists; compliance monitoring by a “health partner” who will be a volunteer; and a medication assessment and planning which will be done by a registered nurse and a pharmacist.

Training materials have been prepared for resident service coordinators and residents. The program will be piloted in select sites early in 2008.

The grant supported housing activities at two Vermont PACE sites. Preliminary feasibility work was completed at one site to establish baseline data to convert a part of the building into temporary and/or respite housing in the future. The Rutland PACE site is co-located in Phase 3 of a Senior Living Community, part of a new 60-unit development (Phases I and II comprise an additional 83 seniors units).

Figure 2: Nursing Facility Supply, 1998 - 2007



Future of Nursing Homes

The supply of nursing facilities dropped 12.5%, from 3,749 in January 1998 to 3,279 in July 2007 (figure 2). Nursing facility use has also declined steadily since 2001. Medicaid bed days have dropped from 805,915 days in calendar year 2001 to an estimated 726,147 in calendar year 2007 or just under than 10% (figure 3).¹² A similar decline occurred in total nursing home bed days (figure 4) and in Medicare and private pay (figure 5).¹³ The rate of decline in the number Medicaid days increased after the implementation of Choices for Care in October 2005.

¹² Available at: <http://dail.vermont.gov/dail-publications/publications-monthly-reports/monthly-rpts-oct-2007/drs-res-days>
¹³ <http://dail.vermont.gov/dail-publications/publications-monthly-reports/monthly-rpts-oct-2007/hx-medicare-days-mthly>; <http://dail.vermont.gov/dail-publications/publications-monthly-reports/monthly-rpts-oct-2007/drs-res-days-pvt-pay>

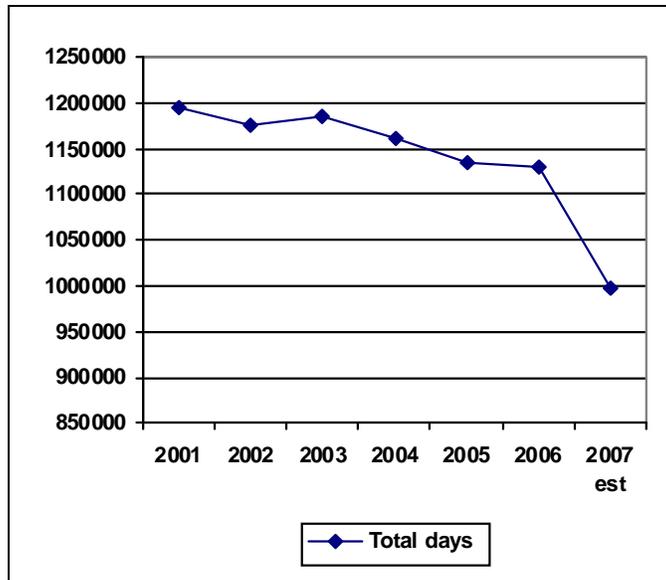


Figure 3: Nursing Facility Annual Total Bed Days, 2001 – 2007

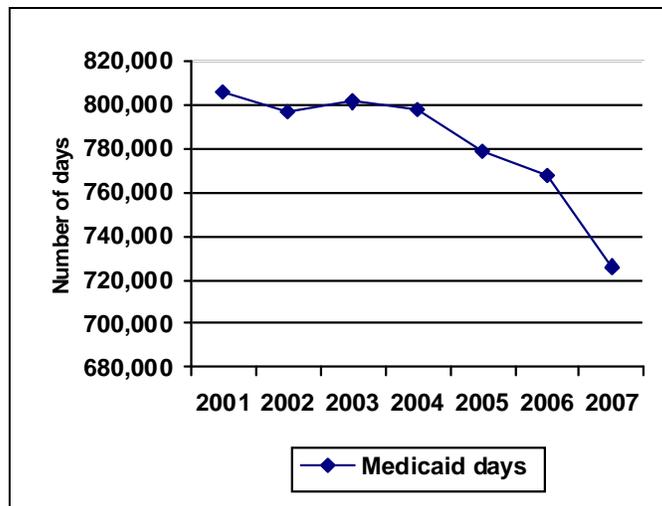


Figure 4: Medicaid Nursing Facility Total Annual Bed Days

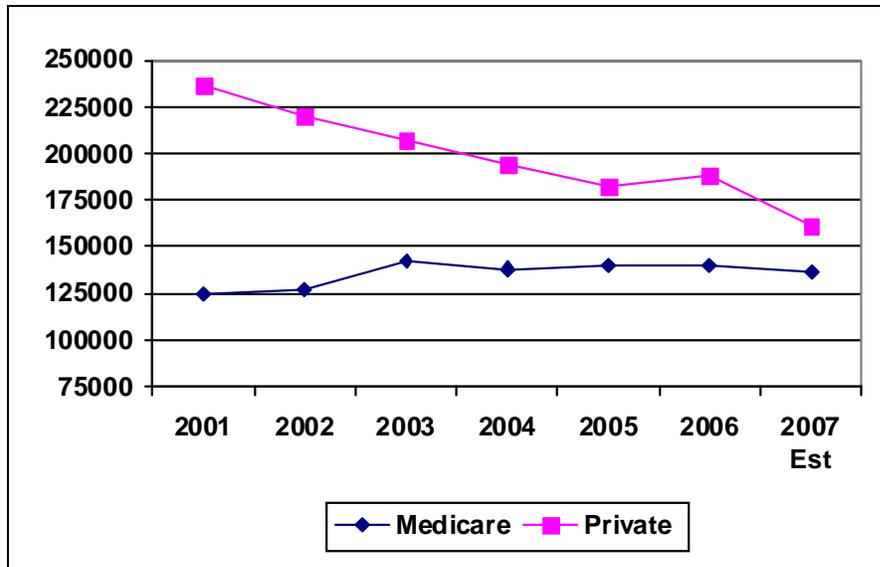


Figure 5: Medicare and Private Pay Bed Days, 2001 - 2007

In 2006 DAIL convened a task force to examine the future of nursing facilities. DAIL submitted a report to the Legislature – Nursing Facilities for the 21st Century – in 2007. The Task Force focused on three primary areas: revenue sources for nursing facilities; right-sizing the industry; and helping nursing facilities become more consumer-responsive and accessible for the benefit of both residents and visitors.

The Task Force recommended that DAIL:

- Support the infrastructure of the Gold Star Council and encourage nursing home facilities to participate in the Gold Star process (which is a recognition program for best employer practices of nursing homes in recruitment and retention of personnel).
- Continue the Nursing Facility Quality Awards as a way to promote quality and best practices.
- Use Civil Money Penalties to promote culture change and celebrate diversity in ways that enhance the quality of life and/or quality of care for residents.
- Strengthen the Long-Term Care Ombudsman program as a way to assist with culture change in facilities.
- Determine whether or not the way allowable costs are allocated for space rented or used for community purposes is a financial barrier to facilities providing those spaces.
- Continue discussions with facilities about the best method for right-sizing the industry, including the model of contracting for resident days. The contracting process should recognize quality care.

- Examine incentives to accomplish right-sizing of the industry such as bed-banking and conversion of multi-bed rooms to rooms with double and single occupancy.
- Research financial incentives and financing mechanisms that can assist current nursing facilities to develop home-like settings.
- Develop criteria to help decide when major renovation projects should be approved.
- Encourage additional palliative care services in nursing facilities.
- Work with facilities to determine what is needed to properly care for geriatric patients at the State Hospital and those being furloughed from the Correctional system who would be better served in a nursing facility.
- Clarify information about assistive technology, i.e. what is covered, by whom, and the most effective ways of obtaining the needed items. Provide this information to facilities, residents and families Identify barriers in the reimbursement system to the effective use of assistive technology and recommend changes at the state and federal level.

DAIL is interested in encouraging development of small-house nursing homes similar to Green Houses. A source of financing is needed to help facilities to bridge the transition period to serve existing residents while new models are built or renovations are completed.

Integration of Acute and Long-Term Care

As stated above in describing State initiatives, Vermont is working on a pilot to integrate acute and long-term care. It also now has 2 PACE sites in operation, described under Array of Services.

Conclusion

Vermont implemented significant organizational and programmatic changes to create a comprehensive, balanced system. DAIL sets goals for balancing their system and tracks progress toward the goals monthly. The Choices for Care Demonstration Program allowed DAIL to create an entitlement to home and community based services for individuals that meet the “highest need” criteria, increase the number of participants receiving services in their home and residential settings by 50% in 2 years and eliminated the waiting list for home and community based waiver services. Combining programs and staff across populations fostered a sharing of resources and support for innovation that led to an expansion of service options for individuals

who were not adequately served by the existing service array. Converting all long term care services to two separate §1115 Demonstration Programs presents new challenges reporting data to CMS in a way that is comparable to data reported by other states. As a result, continued progress toward balancing goals is more difficult to measure using national data, but we conclude that access to services, the array of services, and the availability of person-centered and consumer-directed services are all enhanced by Vermont's current directions. Also noteworthy are Vermont's efforts to eliminate inequities in provider payments between HCBS and nursing home services. Finally, the unified organization within state government is allowing leaders among state officials and community providers to apply some of the housing-with-services options that worked well for people with developmental disabilities to elderly and physically disabled participants who are hard to place in traditional residential settings for the elderly.