

**Rebalancing Long-Term Care Systems in Vermont:
Experience up to July 31, 2005**

Abbreviated Report

submitted to the

**Centers for Medicare & Medicaid Services (CMS),
Advocacy and Special Initiatives Division
CMS Project Officer, 9/1/2004 to 4/15/2006, Mary Beth Ribar
CMS Project Officer, 4/15/2006 to present, Dina Elani**

Researchers on the Project

University of Minnesota

School of Public Health

Rosalie A. Kane, PhD, P.I,

Robert L. Kane, MD, Co-PI

Reinhard Priester, JD, Project Coordinator

Donna Spencer, Data Manager

Center for Community Integration

K Charlie Lakin, EdD, Investigator

School of Social Work

Terry Lum, PhD, Data Analyst

CNAC Corporation

Linda Clark-Helms, CNAC Project Director

National Academy for State Health Policy, Portland, ME

Robert Mollica, Investigator

PAS Research Center, University of California, San Francisco

Charlene Harrington, PhD, RN, Investigator

Martin Kitchener, PhD, Investigator

Consultants

Charles Reed, Olympia, Washington

Dann Milne, Denver, Colorado

The overall project 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. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, and Washington. The baseline case study covers a period through July 31, 2005. Updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was presented for discussion at a CMS Open Door Forum, February 22, 2006. 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 Vermont liaison to the study, Patrick Flood, Commissioner, Vermont Department of Disabilities, Aging, and Independent Living.

Table of Contents

Highlights.....	1
Context.....	2
Real Choice Systems Change (RCSC) Grants.....	2
Programs and Services.....	3
Noteworthy Medicaid state plan and state-funded community LTC services include:	3
Featured Management Approaches.....	4
Act 160 and Rebalancing Target Setting	4
Community Long Term Care Coalitions	5
Choices for Care	5
Attendant Services Program	7
Developmental Services.....	7
“Screen Door” and Electronic Information.....	8
Workforce Development.....	8
Quantitative Markers of Rebalancing	9
Changing Patterns in Nursing Home Use as Marker of Rebalancing.....	9
Balance between Institutional and Community Care.....	10
Conclusions.....	12
Issues for Future Observation	13

Rebalancing Long-Term Care Systems in Vermont: Abbreviated Report

Highlights

Vermont is characterized by innovative management approaches and a commitment to community care for Vermonters with disabilities of all ages.¹ The notable elements include:

- Vermont has established and periodically updates specific numerical goals for institutional long-term care use.
- Through legislation, Vermont has established the principle that savings realized through reduction of institutional use could remain in the LTC budget.
- Vermont established an HCBS waiver for Developmental Disability in 1983 and for seniors and people with disabilities in 1987.
- Vermont has achieved almost complete HCBS provision for people with developmental disabilities, using individual budgeting and a wide array of community services. Community residential care for people with developmental disability is based on almost a one-on-one personal attendant model.
- In 1998 Vermont became one of 3 (now 4) states to offer HCBS waiver services to children under age 22 with serious mental illnesses.
- Vermont operates a long-standing participant-directed attendant care program, funded with state revenues.
- For both seniors and adults with disabilities and for people with mental illness and developmental disability, Vermont organizes its services through systems of designated agencies serving 10 geographic areas—through Area Agencies on Aging and Home Health Agencies for seniors and physical disabilities, and designated mental health and developmental services agencies for developmental disability. These designated agency systems result in quasi-public non-profit agencies with strong commitment to the state's goals and a strong advocacy stance towards consumers.
- Vermont has introduced considerable consumer direction into its attendant care program, and other waivers, and is implementing a cash and counseling program. Consumer

¹ This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Vermont, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, appears on the website HCBS.org and on the University of Minnesota Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, and Washington. The case study covers a period up to July 31, 2005; subsequent reports will update the information as of July 2006 and July 2007.

direction and community integration are embedded in the statute authorizing the Agency for Human Services, and in administrative agency policies.

- The centerpiece of current long-term care activity for seniors and people with physical disabilities in Vermont is Choices for Care, an 1115 waiver demonstration, the end result of about a decade of related efforts. Choices for Care, which became operational in October 2005, creates an entitlement for HCBS waiver services and nursing home care, paving the way for nursing homes to become an alternative to HCBS instead of the reverse. Under this system, the entitlement for HCBS and nursing home care is reserved for the Highest Need group, but the state may and is expected to serve a High Need and a Moderate Need group as resources permit.

Context

- At the state level, the umbrella Agency for Human Services was reorganized in 2004 to house almost all programs related to policy, delivery, and quality assurance for long-term care within a sub-cabinet Department of Disabilities, Aging & Independent Living (DAIL). DAIL is organized along functional lines with no Balkanization of developmental services. Personnel from the highly successful Developmental Services program hold leadership roles within DAIL. The HCBS waiver for children with mental illness remains housed in the Department of Health, a strategy to integrate physical and mental health services. Executive and legislative leadership for long-term care in Vermont reflects stability and depth of experienced personnel.
- State agencies for LTC in Vermont (now largely consolidated in DAIL) have established a standard of community consultation and collaboration, transparency, and feedback, not just with lead agencies for various programs but with the network of advocates, service providers, and citizens.
- Other contextual issues include: Vermont's Global Commitment initiative begun in October 2005 to accept and manage a block grant for its Medicaid program; the development of PACE programs; strong local capacity building for rehabilitation programs including assistive equipment; and a concerted push to improve community mental health programs, close the troubled Vermont State Hospital (a gradually shrinking psychiatric facility), and develop capacity for needed in-patient services in the local communities.

Real Choice Systems Change (RCSC) Grants

Vermont received \$5,489,572 in RCSC funding between 2001 and 2004, the highest amount of RCSC funding per state population of any States in this Rebalancing Study.² Two of the

² In 2001, Vermont was awarded a System Change Grant to permit Aging and Independent Living, Developmental Disabilities, and Mental Health to collaborate to develop a state-wide approach to a consumer-centered service system. In 2004, Vermont was awarded an Integrating Housing and Supportive Services Grant, and a Quality Assurance/Quality Improvement Grant. Also in 2004, it was one of 2 States to receive a Comprehensive Systems Reform Grant to design an integrated care system across acute care and long-term care. Vermont's Aging and

RSCS grants were for systemic reform. A \$2 million Real Choice grant in 2001 helped initiate the activities that led to the new consolidated DAILS, and the plan for what became the 1115 waiver demonstration (Choices for Care), featured in this study. The Comprehensive System Reform Grant is presently exploring several different approaches to coordinate or integrate acute care and chronic disease management with long-term care. These and all the RCSC grants in Vermont engage stakeholders and attempt to increase consumer empowerment and participation. The QA/QI grant is exploring ways to include families, participants, and community members in quality monitoring across all HCBS waivers. The Integrating Housing with Supportive Services involves a public private partnership with the Cathedral Square Corporation, a plan to co-locate PACE projects with two affordable housing projects, and is giving attention to developing medication practices in assisted housing.

Programs and Services

Vermont covers a wide array of services for elderly, adults with physical disabilities and individuals with developmental disabilities. Community services include consumer-directed and agency home care and personal care, a variety of rehabilitative services and group residential services. From 1983 to 2002, Vermont developed five Medicaid section 1915(c) waiver programs: Developmental Services, HCBS (for seniors and younger adults with disabilities), Enhanced Residential Care, Traumatic Brain Injury, and a waiver for children under age 22 with mental illness. The number of enrollees is small; the largest is the development Services waiver with 1,961 enrollees in 2004.

Noteworthy Medicaid state plan and state-funded community LTC services include:

- Assistive Community Care Services (ACCS), a Medicaid state plan service for beneficiaries living in Level III residential care facilities or assisted living residences.
- Participant Directed Attendant Care, available under the Medicaid state plan for individuals who have a severe and permanent disability, need physical assistance with at least two ADLs and are able to direct their own care
- A Homemaker Program funded by general revenues and the Social Services Block Grant for elders and adults with physical disabilities who need assistance with one or more ADL and/or have a cognitive impairment
- A Housing and Supportive Services (HASS) Program coordinating access to existing community services for older adults and adults with physical disabilities who are living in congregate housing settings
- A Flexible Family Funding program funded by state general funds providing up to \$1,122 a year for consumers of any age who live at home with their family
- Children's Personal Care available under the Medicaid state plan as an EPSDT service.

Disability Resource Center, awarded in 2005 (out of the scope of this baseline case study), will involve all target populations, aim for a consistent approach state-wide, and incorporate Medicaid applications and development of a fast-track system for eligibility processing.

Featured Management Approaches

Act 160 and Rebalancing Target Setting

Act 160, passed in 1986, was among Vermont's comprehensive steps toward a balanced system. The Act gave the Secretary of Human Services the authority to reduce the supply of nursing homes

.....if [DHS] develops a plan to assure that the supply and distribution of beds do not diminish or reduce the quality of services available to nursing home residents; force any nursing home resident to involuntarily accept home and community based services in lieu of nursing home services; or cause any nursing home resident to be involuntarily transferred or discharged as the result of a change in the resident's method of payment for nursing home services or exhaustion of the resident's personal financial resources.

The Act prioritized nursing home residents who wanted to relocate to a community setting, anyone on a waiting list who was at the highest risk of admission to a nursing home, others at high risk and people with the greatest social and economic need. It allowed the Secretary to place any unspent funds at the end of each fiscal year into a trust fund for use in subsequent years for HCBS or for mechanisms that reduce the number of nursing home beds. The Act's other reform provisions directed the Department of Aging and Disability (now DAIL) to:

- Create a comprehensive data system
- Implement a system of statewide long term care service coordination and case management
- Include consumer participation and oversight at the state and local level
- Develop long term care service models that are alternatives to nursing home models

Under Act 160, DAIL establishes long-range goals and periodically tracks progress and makes recommendations that, "if implemented, will result in a balanced and sustainable system of care for elders and adults with physical disabilities. To illustrate the specificity of recommendations, below we list selected long-range recommendations from a 10-year plan made in the Year 2000-2001, and Vermont's own appraisal of the progress towards them as of 2004:

- In accordance with consumer preference, continue to decrease reliance on nursing home care. Develop alternatives so that at least 40% of the people needing Medicaid funded nursing home level of care receive that care at home or in other community settings. In 2005, 5 of 12 counties had met or exceeded the target.
- Increase HCBS Medicaid Waiver slots by 100 each year and continue to allocate them to people in greatest need. 2004 status: only 54 slots were allocated in FY 2003 and 88 in FY 2004, and 75 expected for FY 2005.
- Increase the Attendant Services Program to serve 100 more people by 2010. 2004 status : growth was slower than expected with the caseload rising from 250 clients in FY 2000 to 261 in FY 2004. Funds were obtained to support an increase in the number of participant

hours. Just to maintain the 2003 rate of use while keeping pace with demographics, the program would have to serve 58 more clients annually to serve 319 consumers in 2013.

- Continue to improve wages and benefits for personal caregivers in all settings until caregivers receive a starting wage of at least \$10/hour, along with basic benefits such as health insurance, sick time and vacation leave. Wages in all settings should be increased annually by an inflation factor. 2004 status: The only program with a starting wage of \$10/hour is the Consumer or Surrogate Directed Option in the HCBS waiver.
- Increase the capacity of adult day centers to serve 1,500 people in 2010, up from 800 in 2000, reflecting an increase in daily capacity from 441 to 720. 2004 status: daily capacity grew to 584 in FY 2004 and expected to be 989 by the end of 2004.
- Develop additional supportive housing such as Enhanced Residential Care, Assisted Living, group-directed congregate housing, and adult family care, increase funding for home modification, and continue to promote universal design in all new housing construction. Enhanced Residential Care and Assisted Living had expanded, but funding for home modification became increasingly inadequate.
- Expand the Homemaker Program, which served 700 consumers in 2000, to serve 1,300 people by the year 2010. 2004 status: The Homemaker Program shrank to 614 consumers in FY 2003, 86 fewer than in FY 2000. To maintain the 2003 rate of use while keeping pace with demographics, the program would have to serve 404 more clients per year until reaching 1,018 clients in 2013.

All failure to meet targets was attributed to budget constraints.

Community Long Term Care Coalitions

Community Long-Term Care Coalitions are a unique Vermont phenomenon. Vermont has historically included local organizations and individuals in the policy development process for older adults and adults with physical disabilities. Act 160 extended this local involvement to planning and resource development by creating 10 Community Long Term Care Coalitions. These Coalitions are supported in part with state funds from Act 160 and comprised of consumers, providers, advocates, and other stakeholders. Their charge is to review local needs and work with DAIL to improve service coordination. Among the Coalitions' successes are enhanced case management, volunteer caregiver registries, and initiatives to inform the public about LTC options. In addition, each Coalition receives additional funds to fill gaps in local service such as personal care, respite, and adult day. The Coalitions were also the focal point for planning PACE projects (in December 2003, PACE Vermont, Inc was incorporated as a single PACE program with two centers). As funds from Act 160 have diminished, only two of the local Coalitions continue to operate, one supported by a foundation grant.

Choices for Care

The Choices for Care program, an 1115 waiver demonstration program implemented in October 2005, directly confronts the underlying inequity that nursing-home care is an entitlement for all Medicaid beneficiaries who meet the level of care criteria whereas waiting lists may limit

access to HCBS services. The demonstration flips the status quo and creates an entitlement for HCBS services for participants who meet specified criteria. The demonstration will test the hypothesis that targeted early interventions, assessment, case management and the provision of HCBS to frail elders and adults with physical disabilities will:

- Ensure enrollee satisfaction with the long term care services received;
- Reduce utilization of institutional settings; and
- Control overall long term care costs.

Choices for Care will enroll all elderly and individuals with disabilities currently receiving Medicaid services in a nursing home or through the HCBS and Enhanced Residential Care waivers. All spending -- community, residential and nursing home -- will be managed under a capped global budget. DAIL will create three groups of beneficiaries:

- The Highest Need group will be entitled to either nursing facility or HCBS. The threshold is above the current threshold for nursing home or HCBS waivers. At the programs onset, 3,000 current beneficiaries will be eligible at the highest need, 2,200 of whom are in nursing home residents and 800 who are HCBS participants
- The second group, the High Needs group, will be served as funds are available and must meet the existing level of care threshold for nursing home care and the HCBS waiver, but they will not automatically be entitled to services. Approximately 200-300 individuals a year are estimated to qualify for this level
- The Moderate Needs group will include individuals who do not meet current nursing facility or HCBS waiver eligibility criteria, but are at risk of admission to a nursing home. Providing HCBS services to individuals who are at risk will allow DAIL to intervene earlier and delay further decline and possible admission to a nursing home

The Choices for Care program changes the assessment and approval process. Entry to the new system will be through registered nurses employed by DAIL, who will conduct assessments for all applicants for nursing home and HCBS who appear eligible for Medicaid. Hospital discharge planners will no longer be able place Medicaid beneficiaries into a nursing home without an assessment by a DAIL registered nurse. Once approved, the participants who choose HCBS services are referred to the case management agency they selected. In keeping with Vermont traditions, community input was solicited at all stages of developing Choices for Care. Implementation was generally supported by providers, despite concerns that the intake assessment workload might require more than 12 registered nurses and could lead to delays in assessments and placement. Although home health agencies and AAAs lose some of their assessment roles, these agencies support making HCBS an entitlement under the demonstration. If Choices in Care works as anticipated, community agencies will need to develop not only the capacity but also an attitude of willingness to serve some of the most disabled seniors, including persons with Alzheimer's disease and heavy health-care needs in the community. Some home health agencies express some trepidation about being able to staff a flexible, heavy care services in the community. Nursing home providers expect some facilities to reduce their capacity and others to close due to the expansion of HCBS service. On the other hand, some may need to add residential care units, convert nursing home wings to residential care, develop adult day health services, or convert shared rooms to private rooms.

Looking forward, DAIL expects that the Choices for Care demonstration program will expand choice by placing HCBS and nursing home on a level playing field. By making HCBS an entitlement for applicants that meet the highest need criteria, the state will eliminate waiting lists for consumers who wish to remain in or return to the community.

Attendant Services Program

The Attendant Care Program is a consumer-directed program that began in 1980 for adults of all ages with disabilities who need assistance with daily activities. The participant in the program hires, trains, supervises, and schedules his or her personal care attendant. It has four separate components:

- *General Fund Participant-Directed Attendant Care* is targeted to people who have a permanent and severe physical disability and need assistance with at least two ADLs.
- *Medicaid Participant-Directed Attendant Care* is essentially the same service as above, available under the Medicaid state plan to people who meet regular Medicaid financial eligibility criteria.
- *General Fund Personal Services* supports people who have a disability and need assistance with at least one ADL or with meal preparation and are Medicaid eligible
- *Group-Directed Attendant Care* supports individuals who have a permanent and severe disability, need attendant services for at least two ADLs, need four or more hours of attendant services daily, live with other eligible individuals in a group living situation approved by the Department, and are capable of directing their supports

Consumers apply through the local AAA or home health agency and are reviewed by a team that consists of at least three persons - two consumers and a representative from DAIL. Once certified, participants contact the payroll agent to enroll as the employer. Consumers are not allowed to employ anyone with a substantiated history of abuse, neglect, or exploitation as a caregiver. Spouses or civil union partners may be paid to provide services under general fund programs, but not under Medicaid.

State officials estimated that consumer direction saved the state more than \$2 million in FY 2000. A satisfaction survey among program participants found that two-thirds were very satisfied, and one-third was satisfied. Reasons for choosing to participate in the program included: lack of or inadequate home health staff (21 percent), control over who is hired (21 percent), higher personal care attendant wages (17 percent), recommended by case manager (17 percent), and already had a caregiver (13 percent).

Developmental Services

In 1993, Vermont closed the Brandon Training School, the state's only institution for individuals with mental illness and DD, using "bridge funding" from the legislature to expand community services until savings from relocating residents from the Brandon School could be shifted to community programs. About 40% of these individuals now live independently or with family members. Ninety-eight percent (98%) of people receiving residential services live in settings with one or two people and the remaining 2% live in settings with six or fewer individuals.

The Department of Developmental and Mental Health Services (DDMHS) contracts with private, nonprofit community provider agencies to provide community services for persons with DD and mental health disorders. These geographically based Designated Agencies (DA) are responsible for assuring that a comprehensive range of services are available within their defined service area for adults with mental illness, children and adolescents with severe emotional disturbances, and people of all ages with developmental disabilities. A recent analysis of the DA system concluded that “[t]he non-competitive nature of the DA system and the bottom line regional responsibilities delegated to the Designated Agencies has fostered the development of a system of care that is highly effective in meeting the unique needs of Vermont communities. The agencies work with local organizations and providers to identify needs and develop response programs.

Vermont’s system is based as much as possible on one-to-one service delivery, one provider to one client. State officials reported that there are a few group homes and therapeutic homes that serve an average of 1.2 consumers but settings of three or more are actively discouraged. The DA system appears to have accomplished its goals, but some concern has been expressed about unevenness in costs among the 10 DA areas.

“Screen Door” and Electronic Information

AHS and DAIL offer a range of information on their web sites for consumers and family members with access to the Internet. AHS created a web based screening tool, called “Screen Door,” to help consumers identify programs and services that may be available to them.³ The web site prompts individuals to provide basic financial information, age, the number of members in the household, the city or town where they live, benefits they may already received and areas where additional help may be needed—e.g., the person has a behavioral or developmental disability, a vision loss, or needs help finding a job. Based on the information entered, the program generates a brief description of the programs a person may find appropriate, the reasons why the program may be appropriate and the name, address, and phone number of the organization to contact for further information.

Workforce Development

Workforce development has been an ongoing priority in Vermont. In 1999, DAD created a Workforce Task Force (now called the LTC Workforce Council) to consider improving wages and benefits, improving working conditions and building public awareness of the value of direct service workers. Supported by a Real Choice Systems Change grant received in FY2001, the Workforce Council addressed the direct care staffing shortages and developed an action plan designed to create a stable, valued, and adequately reimbursed work force that provides quality care to individuals and families. Based on a Council recommendation, DAIL organized and supported the development of the Vermont Association for Professional Care Providers (VAPCP), a non-profit membership organization for paraprofessional workers to advancing the professional growth, employment opportunities, and quality of life for people who provide personal care and support services in all home, community, and healthcare settings.⁴ A 2004 Better Jobs, Better Care award from the Robert Wood Johnson Foundation will further support

³ Available at <http://screendoor.vermont.gov>.

⁴ <http://www.vermontelders.org/VT%20Association%20of%20Professional%20Care%20Providers.htm>

workforce developments. For this grant, the Community of Vermont Elders (COVE), a consumer advocacy organization, is the lead agency, working with DAIL, the Workforce Council, and the VAPCP. One of the activities is the development of a training framework which will offer certificates and basic training curriculum for personal care attendants. Specialized training in palliative care and dementia care is being developed.

Quantitative Markers of Rebalancing

Changing Patterns in Nursing Home Use as Marker of Rebalancing

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Vermont nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Between 2002 and 2004, the functioning level of elders admitted to NHs in Vermont deteriorated slightly from the average ADL score of 14.29 in 2002 to an average ADL score of 14.63 in 2004 (the possible score of the ADL variable is between 0 and 24: a higher score means higher ADL dependence). During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 1.92 in 2002 to 1.77 in 2004 (the possible score for CPS is between 0 and 6: a higher CPS score means lower cognitive functioning). Moreover, the rate of persons with no cognitive impairment or mild impairment increased. (See Table 1).

Table 1. Change in Nursing Home Acuity Admission and 3 Months Post Admission in Vermont, 2002-2004

	2002	2003	2004
At Admission			
Mean ADL	14.29	14.38	14.63
Mean CPS	1.92	1.84	1.77
3 Months Post Admission			
Mean ADL	13.18	12.93	13.48
Mean CPS	2.43	2.52	2.45

The ADL functioning at 3 months after admission improved slightly between 2002 and 2003 and then deteriorated slightly between 2003 and 2004. The average ADL scores in 2002, 2003, and 2004 were 13.18, 12.93, and 13.48 respectively. The proportion of persons with no ADL dependencies followed the same patterns. For cognitive functioning, the CPS scores deteriorated slightly between 2002 and 2003 and then improved slightly between 2003 and 2004. The CPS score in 2002 is 2.43, increased slightly to 2.52 in 2003 and then dropped to 2.45 in 2004. Moreover the proportion with no cognitive impairment remained stable. These findings suggest that HCBS may have achieved part of its goals in deflecting the clients with lower ADL needs to other services, but the same effect was not seen for cognition. This is consistent with the thrust

under the Choices for Care program to develop resources to serve people with Alzheimer’s disease in the community.

Balance between Institutional and Community Care

Figure 1 traces the numbers of clients served in nursing homes, under various other services provisions of the Medicaid state plan and those served under HCBS waivers. The numbers served in nursing home dropped from 2001 to 2002; the numbers of persons served through home health services increased steadily, as did those served under various waiver programs. The enhanced residential waiver and the DS waiver clientele remained stable.

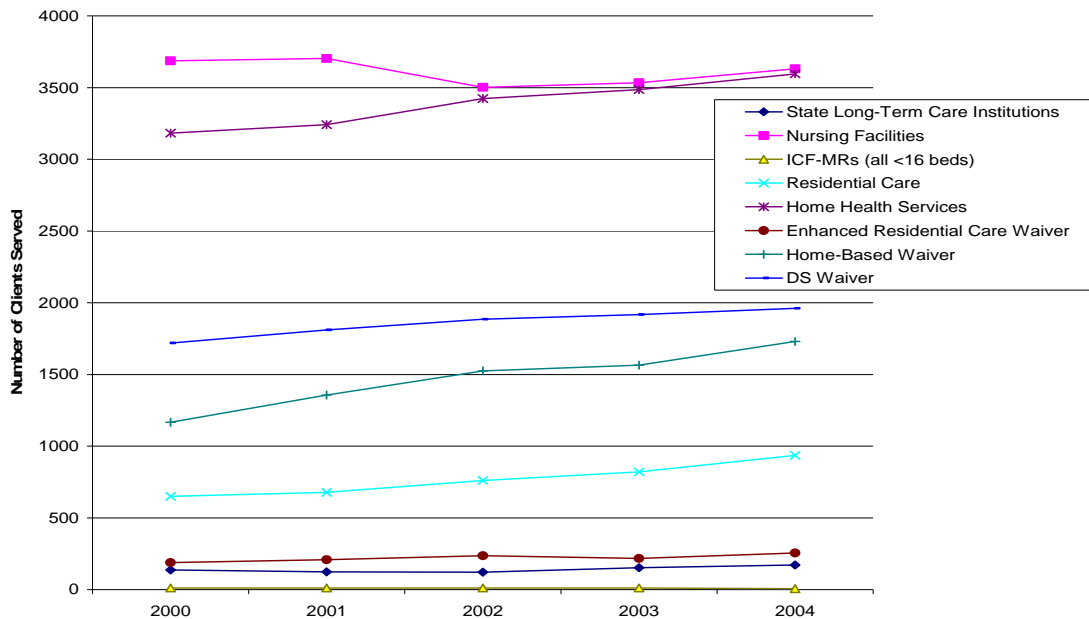


Figure 1: Clients Served in Selected Vermont Programs, 2000-2004

Figure 2 traces the Medicaid expenditure patterns for this same period. Nursing facility, DS waiver, and HCBS waiver expenditures increased while other services remained fairly constant.

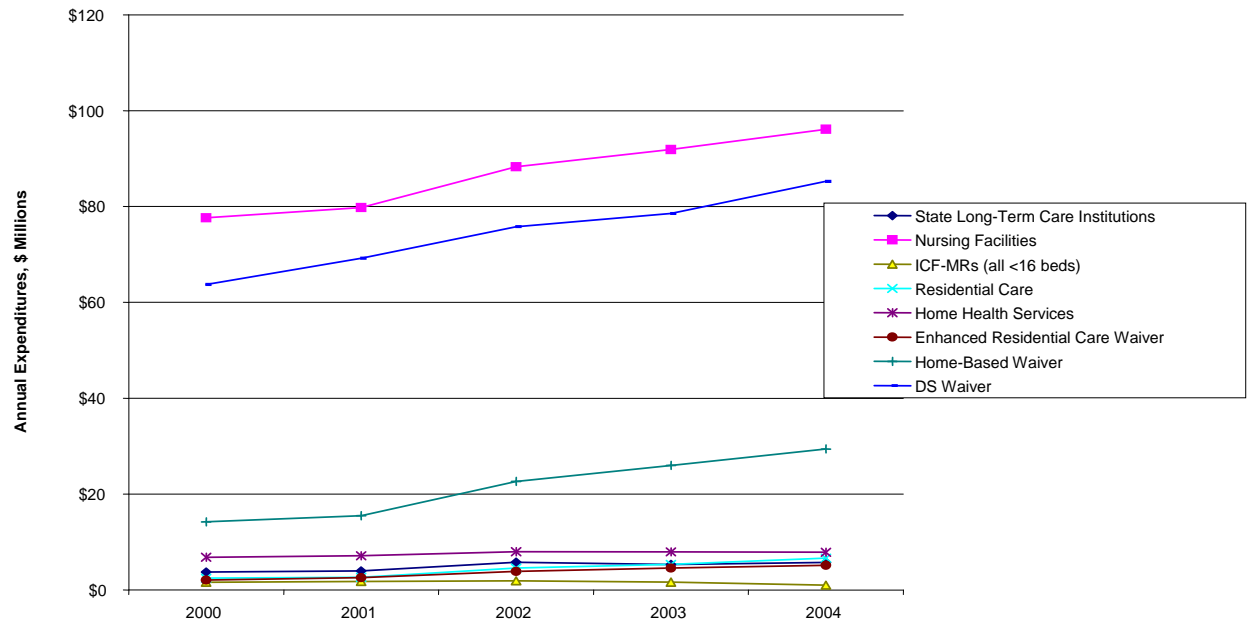


Figure 2: Expenditures for Selected Vermont Programs, 2000-2004

Figure 3 compares the Medicaid costs per client served in nursing facilities and under the HCBS waivers. These costs may be affected by the fact that not all clients are served for a full year. Not only is there a dramatic difference. The cost per client for nursing home residents, enhanced residential care and home-based waivers increased slightly. The costs per client for state long-term care institutions increased in 2002 and then fell back. The costs per client in ICF-MRs rose considerably except for 2003.

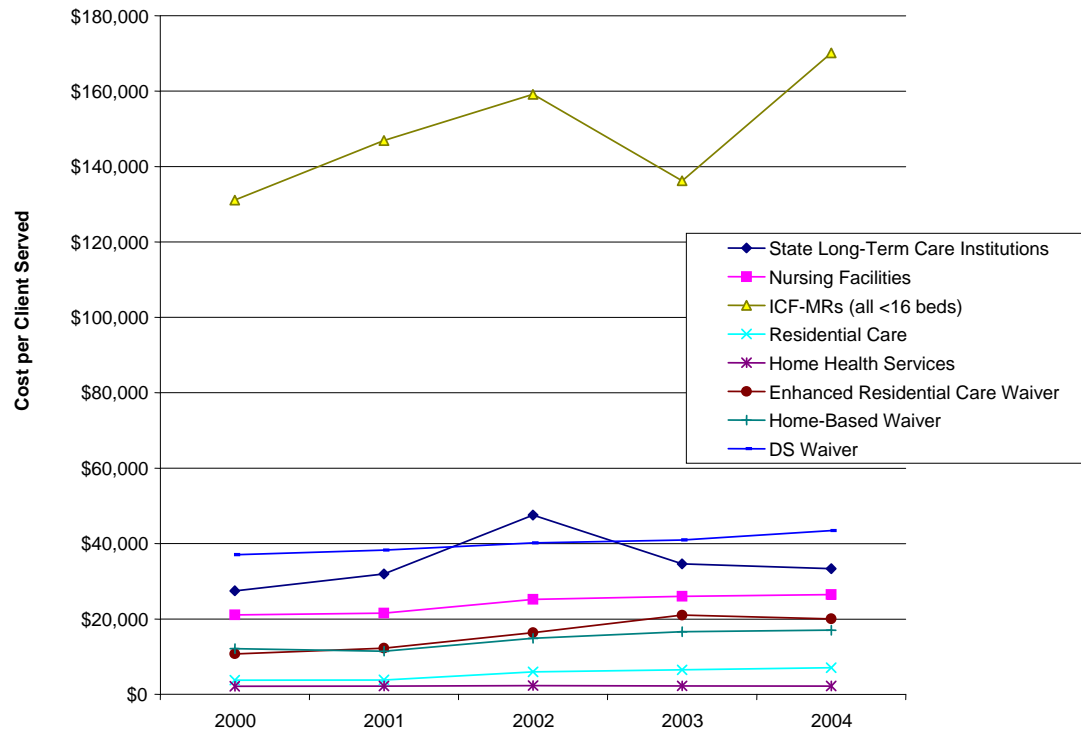


Figure 3. Costs Per Participant in Selected Vermont Programs, 2000-2004

Conclusions

Vermont’s long term care system is led by people who have held leadership positions long enough to gain the support of decision makers, providers, and consumers. Those in charge of the system are seen as credible leaders who have a clear vision and commitment to continuous improvement in the state’s long term care system. The fact that most component parts of the LTC system are located in one state department is an asset and promotes greater efficiency and effectiveness in planning, developing, and delivering long term care services throughout the state. Even those parts of the system not directly under the control and supervision of DAIL are located within the same umbrella agency and work closely with the program.

Vermont set benchmarks for balancing its LTC system and designed an array of strategies to achieve them. Concerns about access and fragmentation in the early 1990s led to a refocusing of resources on consumers rather than infrastructure. Along the way, DAIL designed a delivery system that created choice and shared roles for AAAs and home health agencies. State officials also involved stakeholders in the allocation of resources and coordination of Medicaid and other resources to meet priority needs.

The system for mental retardation and developmental disabilities is exemplary in terms of community integration. Under the Choices for Care 1115 Waiver Initiative, Vermont will

determine the extent to which it can achieve a similar feat for elderly persons living in nursing homes.

Issues for Future Observation

- Early implementation of the 1115 waiver, and the extent to which it can further change the balance of service, especially for persons age 65 and older.
- Realignment of nursing homes in Vermont. The State may be positioned to consider small group nursing homes such as Green Houses, and a variety of other ways to change the structure and culture of nursing homes. Just as Vermont evolved very small group homes and a few small ICF-MRs, perhaps it is poised to reinvent a small nursing home for the 21st century without the disadvantages in quality of the old “mom-and-pop” nursing homes that predated 1965.
- Reactions and adjustments among local community providers to the new system of access for seniors and persons with disabilities.
- Implementation of the PACE projects and other managed care initiatives.
- Continued administrative evolution of DAIL. Although developmental programs and aging and physical disability programs have been merged at the state level, there still appears to be two distinct delivery systems at the local level that do not have much impact on one another, but projects underway are designed to bring uniform practices in access and quality assurance to all populations.
- The effects of the workforce policies under development.

In watching all of these developments, policy analysts must be mindful that Vermont is a small laboratory in the sense of population served. Examining all inter-related elements of a system is made easier by Vermont’s scale. How the lessons from Vermont might be adapted to a much more populous state requires further consideration.