

Rebalancing Long-Term Care Systems in Vermont

Long Version Report prepared by the Rebalancing Research Group

Submitted to the Centers for Medicare and Medicaid Services

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December 2005

The overall project was 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 called for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, New Mexico, Pennsylvania, Texas, Vermont, and Washington. The baseline case study covers a period through July 31, 2005. An abbreviated version of this case study is also available at

http://www.hpm.umn.edu/ltcresourcecenter/research/rebalancing/attachments/baseline_state_case_studies/Vermont_abbreviated_baseline_case_study.pdf

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.

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Preface

The baseline case studies performed for this project were prepared in two forms: an abbreviated case study of approximately 15 pages, and a much longer report, of which this is an example.

Each longer report is organized in 4 sections: context; system assessment; management features, and quantitative markers of rebalancing. The first 2 sections use uniform headings for all reports. The Context section includes: demographics and economics, geography, rebalancing status in brief, political climate, vision and values for LTC, leadership, state government organization for LTC, local organization for LTC, litigation related to re-balancing, advocacy environment, service environment, and a historical and descriptive review of programs and Services. Maps, organizational charts, and statistical background tables are provided beyond the material in the abbreviated reports. The System Assessment categories found in most long reports are: access to services, array of services, consumer direction, quality initiatives, institutional downsizing, data capacity, links to acute care, and links to housing. The illustrative management approaches in Section III are presented in considerable detail. Section IV presents data on supply of services and quantitative comparisons of utilization and expenditures in home-and-community based long-term supports versus institutional long-term support services from 2000 to 2004.

In these baseline reports, we endeavored to trace the evolution of long-term supportive services in the State back to their post-Medicaid and post-Medicare beginnings, with particular emphasis on developments

Rebalancing Long-Term Care Systems in Vermont Summary of Highlights

Vermont's long term care (LTC) system has evolved steadily following decisions in the early 1990s to offer consumers a choice of service settings, to develop a plan to balance spending between nursing home and home and community based services (HCBS), and to work with wide-ranging consumer and provider input on strategies to implement that vision. Vermont was a pioneer in espousing values and goals embodied in the Americans with Disability Act (ADA) and the New Freedom Initiative. Unlike most states, Vermont has established and periodically updated numerical goals for specific institutional reduction targets in institutional use within specified time periods. It also established the principle through legislation that savings realized through rebalancing could remain in the LTC budget. Having achieved almost complete HCBS provision for people with developmental disabilities and after some false starts in moving towards widespread community care for seniors at the nursing-home level of need, Vermont now is poised to make leaps in community care for people over age 65 and adults with physical disabilities.

Vermont initiated its first HCBS waiver for developmental disability as soon as the program became available in 1983. At present, it offers a full array of in-home, community, residential and institutional service options for elders and adults with disabilities using combinations of state general revenues, Medicaid home and community based services(HCBS) waivers, and Medicaid state plan services. Having closed its only state institution for people with developmental disabilities in 1993, Vermont evolved a highly deinstitutionalized, "normalized" program for MR/DD based on a companion model, which almost sets up a single consumer with his or her own residential plan. The average number of residents in a group home is 1.2. Vermont is also

one of only 4 states to operate an HCBS waiver for persons under 22 with mental illnesses requiring hospitalizations.

Agencies responsible for long term care in Vermont, which all exist within the umbrella Agency of Human Services (AHS), were reorganized in 2004. Previously, the Department of Aging and Disabilities (DAD), the Department of Developmental and Mental Health Services, the Department of Health, and the Vermont Office for Health Access (Medicaid) were situated as parallel units within the Agency for Human Services (AHS), the umbrella agency. The reorganization created a new sub-cabinet agency called Disabilities, Aging and Independent Living [DAIL]), comprised of DAD, the Developmental Disability Program, and the Children's Personal Care and hi-technology programs (formerly from the Office of Vermont Health Access, which is the Medicaid program). The mental health component of the eliminated Department of Developmental Disability and Mental Health was moved to the Department of Health, presumably to better integrate physical and mental health concerns. DAILS has been assigned responsibility for all long term care policy and services. Thus, the reorganization integrates policymaking and programs for aging and disabled adults and for people with mental retardation and developmental disabilities functionally across DAIL rather than compartmentalizing MR/DD into a single self-contained unit within DAIL. Medicaid acute care services and financial eligibility are managed by other departments within the umbrella agency. The new organization is described in detail in this case study in Section I.

The centerpiece of current activity is the new Choices for Care 1115 waiver, which is the end result of more than a decade of related activity. In 1996, the legislature passed Act 160, which reduced spending on Medicaid nursing home services, shifted resources to community programs, expanded waiver slots, and supported collaboration and coordination among local community

agencies. This law allowed funds appropriated for nursing home care to be spent on waiver services and other HCBS efforts, and on activities to identify and fill service gaps at the local level. Act 160 expanded HCBS waiver slots and supported collaboration and coordination among local community organizations. In 2003, the state began designing “Choices for Care,” a Section 1115 demonstration program that creates an entitlement for home and community based waiver services and nursing home care for elderly and adults with physical disabilities who meet specified criteria that puts them in the so-called “highest needs” group. Essentially Choice for Care, which became operational in October 2005, eliminates the exact coupling of Medicaid waiver eligibility and nursing home eligibility, eliminates slots and waiting lists for the Highest Need group, and paves the way for nursing homes to become an alternative to HCBS instead of the reverse.

The Choices for Care Initiative is being watched closely nationally as a possible model; we highlight that initiative and the policy work that preceded it in Section III of this report, and plan to track it throughout this 3-year project. Also highlighted are: Act 160, a deliberate exercise in re-balancing that was the precursor to Choices for Care, the Community Long-Term Care Coalitions that were part of the strategy for initial rebalancing; a web-based access tool called “Screen Door, a longstanding Participant-Directed Attendant Care program; and the array of community services developed for MR/DD.¹

¹ Note: The team site-visiting Vermont on June 8-10, 2005 included Robert Mollica from the National Academy for State Health Policy, Donna Spencer from the University of Minnesota, and Charley Reed from Seattle, Washington.. This report is based on information gathered before, during, and after the site visit. In the baseline case study, we created a historical record and context for a period up to July 31, 2005, with the intent of up-dating the case study twice, as of July 31, 2006 and July 31, 2007. We thank our Vermont study liaison, Patrick Floor, Commissioner, Department of Aging and Independent Living, and the many individuals in the public and private sector who provided us with insights for the report. The conclusions drawn are those of the authors and do not necessarily reflect any officials in Vermont or at CMS.

Section I: Context for Rebalancing

Demographics and Economics

Vermont is a small New England state with a population of 621,394 people in 2004; only the State of Wyoming was less populous. The Census Bureau estimated that in 2004, Vermont ranked 18th oldest among states with 12.7% of Vermonters over 65, and was ranked 17th for population over 85, which was 1.4% of the population (see Table 1). Vermont's population increased only 6.4% in the decade from 1994 to 2004, compared to 11.6% increase for the nation.

Table 1. Demographic Features Linked to LTC Needs in Vermont

Population Characteristic	Vermont	United States
Total Population, 2004	621,394	293,655,404
Persons Age 65+ in community, 2004 ^a	12.7%	12 %
Persons Age 85+ in community, 2004 ^a	1.4%	1.3%
Population Minority, 2004 ^a	3.4%	24.3
Urbanicity, 2003 (Percent of Population in MSA) ^a	29.9%	81.7%
Percent of Community Population 5 to 20 with a disability, 2004 ^a	13%	12.1%
Percent of Community Population 21-64 with a disability, 2004 ^a	9.6%	6.5%
Percent of community Population 65 + with a disability, 2004 ^a	37.3	39.6
Persons over 65 with disability, 2003 ^a	45.9%	46.1%
Non-elderly persons with disability, 2003 ^a	11.6%	10.9%
Percent of persons over 65 with care difficulty 2003 ^b	8.1%	9.2%
Men per 100 women over age 85, 2002 ^b	67.1	47.9
Percent of Person 85+ Living Alone, 2003 ^b	53.4%	50.2%

^a These statistics come from the U.S. Census Bureau, American Community Survey, which excludes persons living in institutions, e.g. nursing homes. The definition of disability used in the survey is broad, including persons who report that they have a disability affecting employment, mobility, and/or personal care. Data, last accessed October 14, 2005, is available on web at: <http://www.census.gov/acs/www/Products/Ranking/index.htm>

^b These more detailed analysis regarding older people are in Gibson, Houser, & Fox-Grage (Reference 2)

Vermonters were only slightly older than the U.S. population as a whole, at 12% over 65 and 1.3% over 85. Projecting from the 1990 census, by 2025, 20.4% of Vermont residents will be

over age 65 compared to 18.5% in the United States.² Only 1.9% of the population over age 65 is a member of a minority group and only 29.9% live in urban areas; both of these figures dramatically vary from national averages that show 24.3% of Americans are minority group members and 81.7% live in urban areas. Disability levels among community-dwelling children and adults aged 21-64 are higher in Vermont than the national average, whereas disability among seniors is lower than the national average. More detailed analyses regarding older people, amassed by AARP using 2002 data,³ show that 8.1% of people age 65 and older have self-care limitations, 16% have mobility limitations and 11.5% have cognitive or mental limitations. Fifty-three percent (53% of the people over age 85 live alone).

By some measures, Vermont's population is well off financially (see Table 2). The mean per capita state taxes paid by Vermonters are 3rd highest in the nation.⁴ About a quarter of the revenue is derived from each of property tax, individual income tax, and selective sales taxes on items like gasoline and alcohol. Another almost 15% comes from general sales tax. Vermont's general state expenditures were \$6224 per capita, slightly above the US average. Vermont spent 25.6% more per capita for public welfare expenditures (including Medicaid) and 27.1% more for higher education than the national average, whereas in 2004 the increase in elementary and secondary school expenditures was slight.

² Campbell, P (1997). "Population Projections: States, 1995-2025." Current Population Reports, US Department of Commerce, May 1997, P25-1131.

³ Gibson, MJ, Gregory, S R, Houser, AN, Fox-Grage, W (2004). Across the States. Profiles of Long-term care. Washington, D.C., AARP Public Policy Institute.

http://www.aarp.org/research/reference/statistics/across_the_states_profiles_of_longterm_care_2004.html

⁴ The Rockefeller Institute of Government in Albany, NY generates reports on state and local revenues and expenditures, most of which are on its website at: <http://rfs.rockinst.org/>. Also state summaries can be found on Websites maintained by the Bureau of Economic Analysis, US Department of Commerce, including: <http://www.bea.doc.gov/bea/regional/bearfacts/statebf.cfm>. Both last visited October 15, 2005.

Table 2: Economic Characteristics in Vermont and the United States

Economic Characteristic	Vermont	United States
State taxes per capita in 2002	\$1,767	2,025
Median household income, 2004	\$46,543	44,684
Mean Per Capita Income in 2003 (in constant 2000 dollars)	\$29,186	\$30,033
Population in Poverty (3 year average 2001-2003)	9.4%	12.1%
Population unemployed (2003)	3.7%	5%
Persons without Health Insurance, (3 year average 2001-2003)	9.9%	15.1%
Households with Cash Public Assistance in 2004	3.1%	2.4%
Persons Over Age 65 in Poverty in 2002	7.5%	9.7%
Medicaid participation as % per population, 2003	25%	18%
Community dwelling persons age 5-17 with disability in poverty, 2004.	32.4%	27.0%
Community dwelling persons age 18-64 with disability in poverty, 2004	21.3	24.5%
Community dwelling persons age 65 + with disability in poverty, 2004	10.0	13.1%
Community dwelling persons age 5- 17 with disability to 200% of poverty, 2004	52.4%	61.1%
Community dwelling persons age 18-64 with disability up to 200% of poverty	41.7%	46.9%
Community dwelling persons age 65 + with disability up to 200% of poverty	42.5%	43.0%
Community dwelling persons age 5 to 17 with disability up to 300% of poverty	70.0%	68.1%
Community dwelling persons age 18-64 with disability up to 300% of poverty	59.7%	63.5%
Community dwelling persons age 65 + with disability up to 300% of poverty	65.8%	63.4%

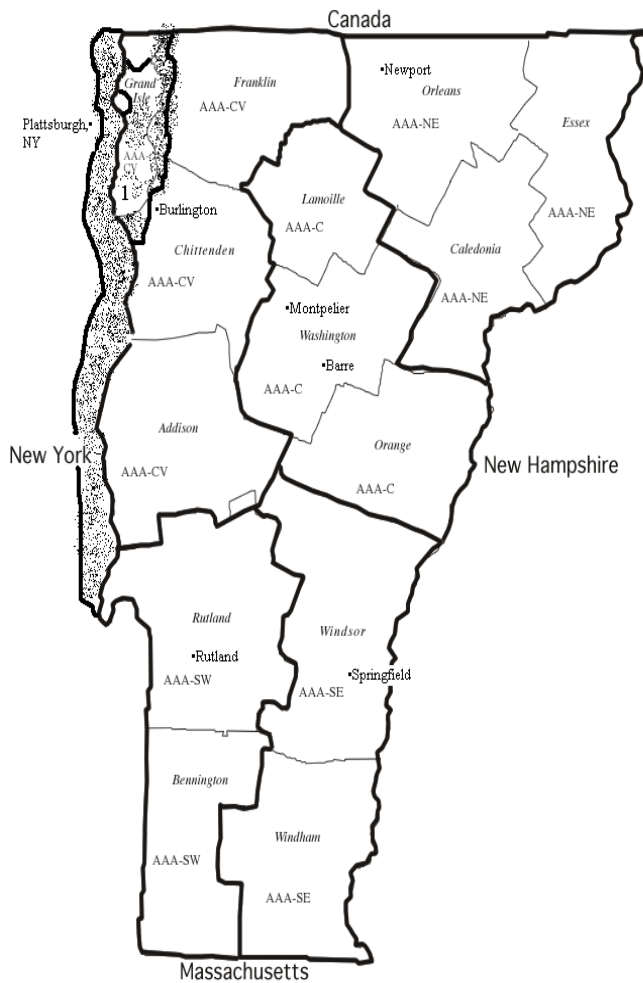
Sources: See Reference 3 and 4 for state and local tax data and health insurance data, respectively. Also from the American Population Survey, U.S. Census.

Using 2003 data, Vermont’s mean per capita income ranked only 22nd at \$29, 186, close but a bit below the national average of \$30,003. According to 2004 data, however, 9% of the state’s population lives in poverty, which is considerably below the national average of 13.1%. Using 2003 data, 54.2% of Vermont residents were in households earning more than 300% of the federal poverty level, compared to 51.4% nationally. The percentage of people over 65 living in poverty is less than in the US as a whole, but the proportion of all persons over age 5 living in poverty with a disability is greater than nationally. Less than 10 percent of Vermont’s residents lack health insurance compared to 15.1 percent nationally.⁵

⁵ DeNavas-Walt, C, Proctor, B, & Mills, RJ (2004). Income, Poverty, and Health Insurance Coverage in the United States: 2003 (U.S. Census Bureau Report, August 2004, P60-226). Washington, DC: U.S. Department of Commerce.

Geography

Vermont occupies 9,250 square miles. The population is somewhat evenly spread, with a density of 65.8 people per square mile. It is divided into 14 counties. By far the most populous is Chittenden County where Burlington is located and which, in the 200 census, had a population of 146,571. Two counties, Essex in the Northeast, and Grand Isles in Lake Champlain had populations fewer than 7,000. The largest city is Burlington, which in 2000 had a population of 38,889, followed by Rutland with 17,292 and Bennington with 15,737. As noted in the Table 1, Vermont is predominately rural, and contains a large number of towns and villages with populations well under 10,000. Although its racial minority population is minuscule, it has a substantial population of French-speaking residents near the Quebec border. It is in easy reach of Plattsburgh, NY and Montreal, Quebec on the North. (See Figure 1 for map.) The size of the state lends itself to centralization of state services, yet a strong tradition of local community involvement co-exists with vigorous state planning.



AAA Coverage Areas in Vermont
 NE- Northeastern Area Agency on Aging
 C- Central Vermont Council on Aging
 SE- Southeastern Vermont Council on Aging
 SW- Southwestern Vermont Council on Aging
 CV- Champlain Valley Agency on Aging
¹ Grand Isles County is an island county located in Lake Champlain and is part of the Champlain Valley AAA.

Figure 1. Vermont Map, with Counties and Areas Agency on Aging PSAs

Rebalancing Status in Brief

In fiscal year 2004, 57.7% of Medicaid long term care funds were spent on HCBS for all populations compared to 54% in FY 2000.⁶ Vermont ranked 11th among all states 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%, a marked increase from 14% in FY 2000.

Community spending for people with development disabilities rose from 97% in FY 2000 to 99% in FY 2004. Having achieved almost complete community care for people with mental

⁶ Brian Burwell, Kate Sredl, and Steve Eiken. Medicaid Long Term Care Expenditures in FY 2004. Thomson Medstat. May 11, 2004.

retardation and developmental disability, the remaining issues for that target population involve maintaining high quality and maximizing community integration. The focus of rebalancing efforts in the sense of reducing dependence on institutions has shifted to the elderly population.

Political Climate

Vermont has a record of commitment to health care and other human services, and a tradition of innovation, risk-taking, and problem-solving around these issues. It has historically been willing to consider state-wide solutions for health financing and delivery. In the 1993s, under Democrat Governor Howard Dean, Vermont considered state-run universal long-term care insurance; the initiative passed the state house of representatives, but died in the senate. Under Republican Governor Jim Douglas, in 2005 Vermont accepted a guaranteed level of spending for Medicaid in exchange for flexibility to run the program, and federal initiative that many states have been leery to accept lest they be left holding an expensive bag. The amount of the federal commitment is to be no more than \$4.7 billion combined federal and state funds over the next 5 years. According to newspaper reports, the state plans to administer Medicaid through a statewide managed care organization, and expresses confidence that the costs will fall below the guaranteed amount, perhaps ending up at about \$4.3 billion.⁷ This initiative is likely to receive much political and policy attention from both legislative and executive branches in the next few years, and will be part of the context for continued rebalancing.

Like other states, Vermont is preoccupied with containing costs and with balancing budgets (and the budgets have been balanced in FY04 and FY 05). But the emphasis seems to be more on efficiency and value to the Vermonter rather than program cuts. Besides Medicaid changes, the current Governor's health initiatives include transparency in drug pricing; increasing coverage for over-the-counter medications; negotiating deeper discounts for pharmacy programs

⁷ Vermont Deal Seeks to Curb Medicaid Costs, The New York Times, October 2, 2005.

by pooling with other states; preventive health programs for all ages; and mental health and substance abuse treatment. Besides health issues, the current administration has a strong emphasis on economic development, transportation infrastructure, and job creation (while at the same time opposing federal efforts to weaken environmental protections). In summary, Vermont continues a bipartisan tradition of fiscal conservatism combined with commitment to its citizenry and creative state initiatives. Given the small and possibly relatively shrinking population, economic growth is a necessary theme.

Vision and Values for LTC

The state legislature established a strong vision for aging and disability more than a decade before the Olmstead decision. It enunciated principles of community integration in statute prior to the enactment of the Americans with Disability Act in State Statute.⁸ The law governing the Department of Human Services states in Title 33, Chapter 5:

It is the policy of the state of Vermont that all older Vermonters and Vermonters with disabilities should be able to live as independently as they choose and as their personal circumstances permit; be able to receive services and benefits which they need and to which they are entitled by law; be able to be full and active participants in the life of their communities, including competitive employment consistent with their abilities and interests; and be protected against unlawful and unnecessary restriction.

In 1989, additional language was added to emphasize the seriousness of this mission: “The laws pertaining to the department of aging and disabilities and its programs shall be construed liberally to carry out the policies stated in this section.”

As already indicated, all individuals with developmental disabilities are served in community settings. In 1996, the legislature enacted the Developmental Disabilities Act of 1996, which

⁸ Title 33 (Human Services), Chapter 5 (Aging and Disabilities), Section 501. On web at: <http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=33&Chapter=005> Last visited, October 16, 2005.

further identified the values underlying the programs and their pertinence to people with mental retardation and developmental disability. The Act asserted that "... each citizen with a developmental disability shall have the following opportunities:

- To live in a safe environment with respect and dignity.
- To live with family or in a home of his or her choice.
- To make choices which affect his or her life.
- To attend neighborhood schools, be employed and participate in activities to the extent that this purpose is not construed to alter or extend rights or responsibility of federal laws relating to special education.
- To have access to the community support and services that are available to other citizens.

In 1998, the legislature adopted ten Outcomes for Well-Being for Vermonters. Among these general outcomes related to health, education, and employment, Outcome 9 reads: "Elders and people with disabilities live with dignity and independence in the settings they prefer."⁹

Principles of community integration and consumer choice are interwoven in Vermont statutes, regulations, and department policy statements. In another example, the Division of Mental Health within the Department of Health operates under a clearly articulated set of goals that mental health services be considered an integral part of health care services, that services be consumer and family driven, that they respond to wants and needs of the citizens, and that they be available in local communities.¹⁰ Finally, besides articulating a value related to outcomes of independence, choice, and community integration, Vermont agencies also articulate and practice the value of inclusion of community stakeholders, including people with disabilities, in policy decision-making.

⁹ Vermont Olmstead Commission (2005). Draft Vermont Olmstead Plan. (October 14, 2005). This document tracks value statements historically. It is on the web at: http://www.ahs.state.vt.us/docs/finalplan_dr101405.pdf Last visited on October 15, 2005.

¹⁰ Vermont State Agency of Human Services (2004). Vermont's Designated Agency System for Mental Health, Substance Abuse & Developmental Services: System Evaluation and Five-Year Projection of Service Demand and Cost Analysis (report from the Pacific Health Policy Group, November 1, 2004). Montpelier, VT. On web at: http://www.healthyvermonters.info/mh/pubs/DA_demand_cost1.pdf Last visited November 14, 2004.

Leadership

State legislators and state officials provided leadership to develop the state's policy initiatives. Two state legislators, David Yacavone and Edward Paquin, built support for Act 160 in the mid-1990s. Yacavone later become commissioner of the new department of Department of Disability and Aging (DAD) and implemented the Act, while Paquin became the director of Vermont Protection and Advocacy.

Continuity of leadership can be found in the executive branch as well. Patrick Flood, the current commissioner of DAIL, has had leadership roles in Vermont since 1988. Before being appointed director of DAD in 1999 (from which he moved to DAIL in 2004), he served as the director of the Division of Licensing and Protection (which certifies Medicare and Medicaid providers, licenses nursing homes and board and care homes) and director of Advocacy and Independent Living (which manages all of the home care and independent living services.) Flood led the design, development and implementation of the Choices for Care demonstration. Theresa Wood has 25 years experience with the Division of Developmental Services, formerly part of the Department of Developmental and Mental Health Services. She served as Director of the Division for seven years, and was appointed Deputy Commissioner of DAIL when the two agencies merged in 2004.

State Government Organization for LTC

The Agency of Human Services (AHS) is an umbrella agency with multiple departments for health, social services, and corrections (See Figure 2). In 2004, AHS was reorganized and a new Department of Disabilities, Aging, and Independent Living (DAIL) was created from the Department of Aging and Disabilities, the Developmental Services Division, and the Children's Personal Care and Hi-technology programs (formerly in the Office of Vermont Health Access,

which houses Medicaid. DAIL reports directly to the Secretary of HHS and is responsible for all long-term care and long-term support policy and programs. The Mental Health Division of the now eliminated Department of Developmental and Mental Health Services moved to the Department of Health; this latter plan was designed to better integrate health and mental health services. Figure 3 diagrams the changes in the Agency of Human Services, showing movement of units. The reorganization resulted in some streamlining and simplification, but also in what was considered to be a more effective functional organization.

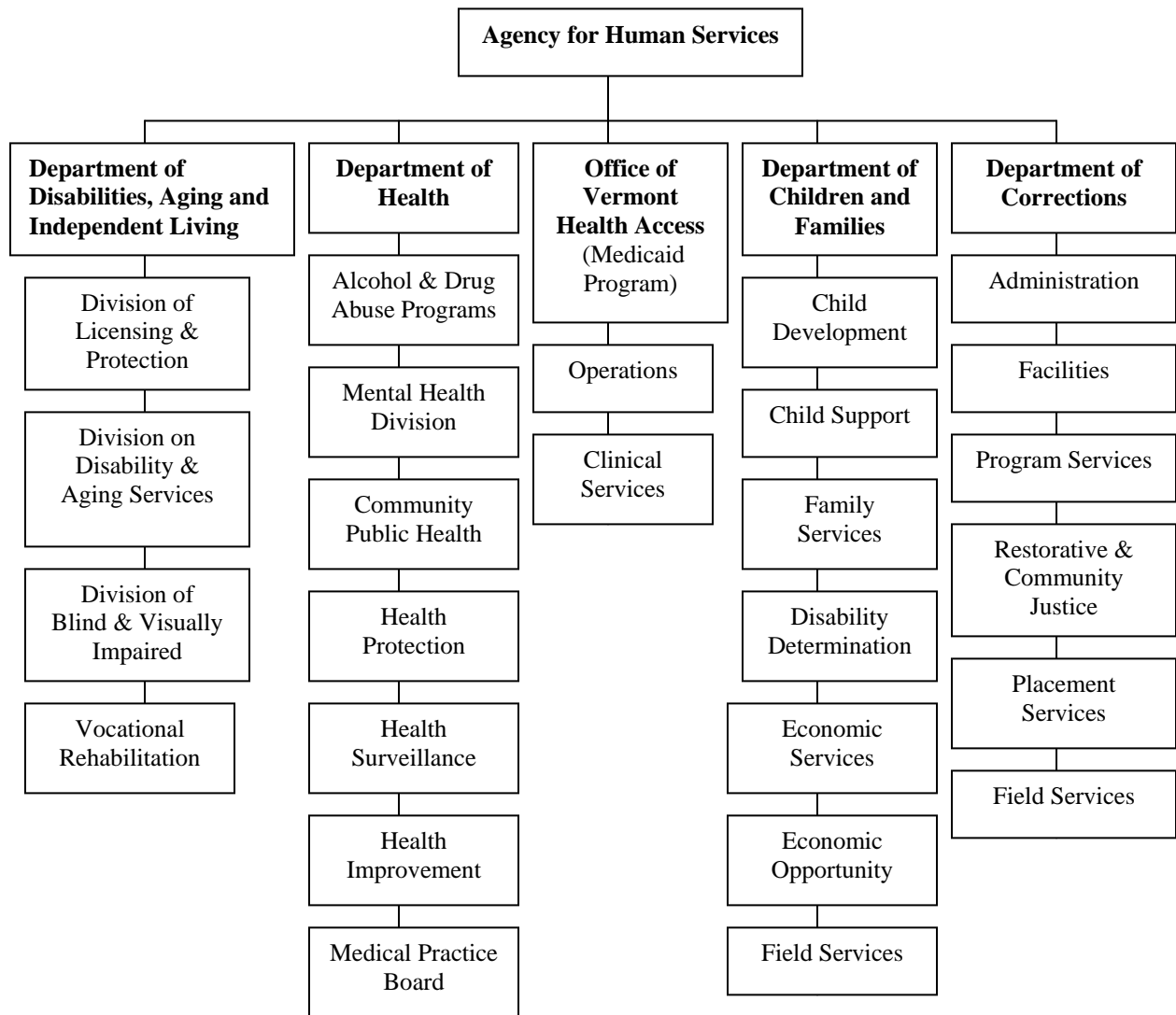


Figure 2. Organizational Chart for Vermont Agency of Human Services, July 2005.

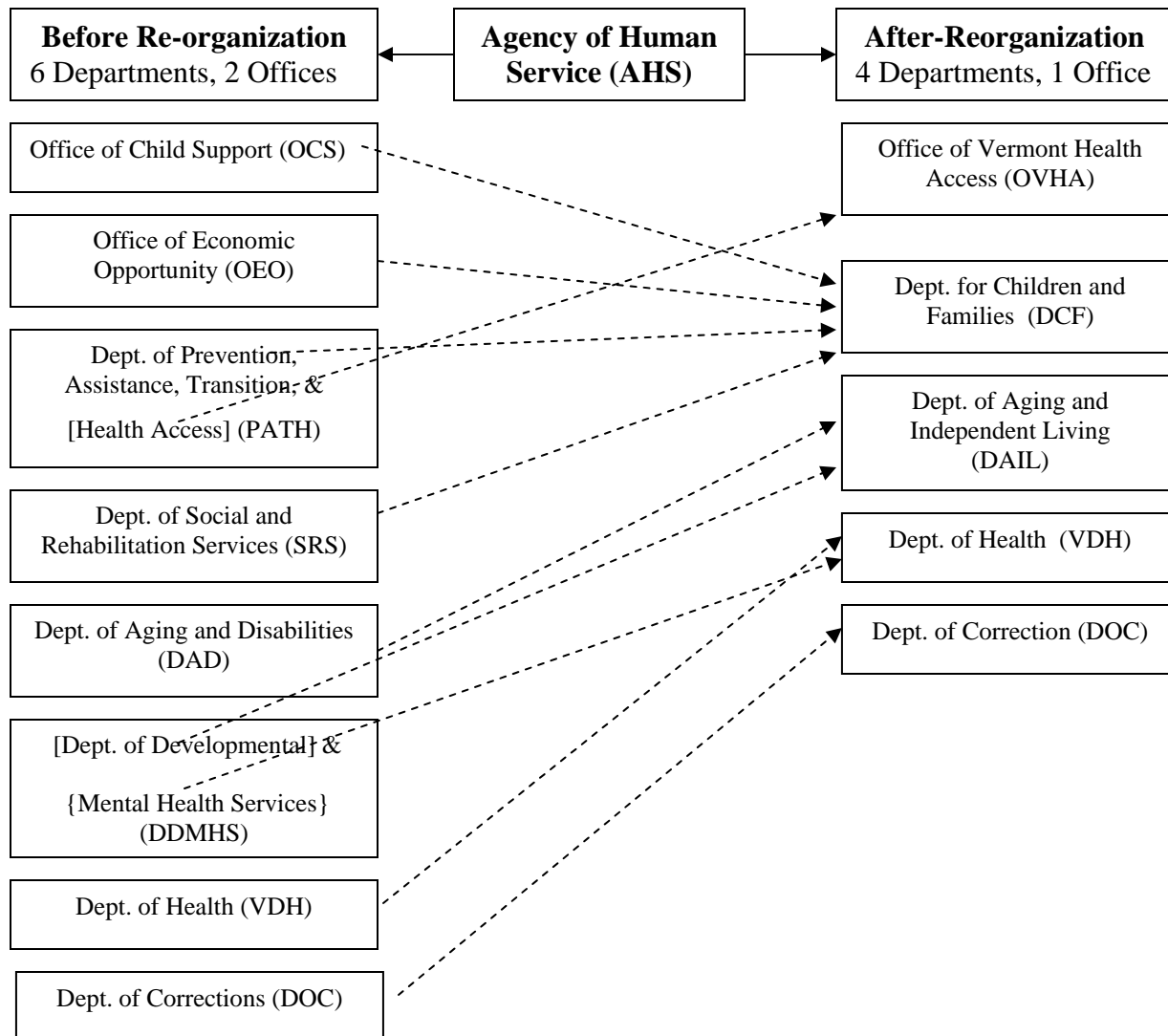


Figure 3. Changes in the Vermont Agency of Human Services after its 2004 Re-Organization

Source. Adapted from Smith, 2005¹¹

With its latest reorganization in February 2005, DAIL has 4 divisions: Disability and Aging Services; Vocational Rehabilitation; Blind and Visually Impaired; and Licensing and Protection. Additionally, an Office of General Support supplies functions such as accounting, legal services, human resource management, and information technology (see Figure 4). Patrick Flood, former head of DAD became Commissioner of DAIL and Theresa Wood, formerly head of the Division

¹¹ Smith, Charles (2005). *Blue Book, 2005. The Agency of Human Services: Opportunities and Pressures, Accomplishments and Caseload Data.* (Annual report from Secretary of the Agency for Human Services, February 2005). On web at: <http://www.ahs.state.vt.us/publs/docs/2006BlueBk.pdf> Last visited November 13, 2005.

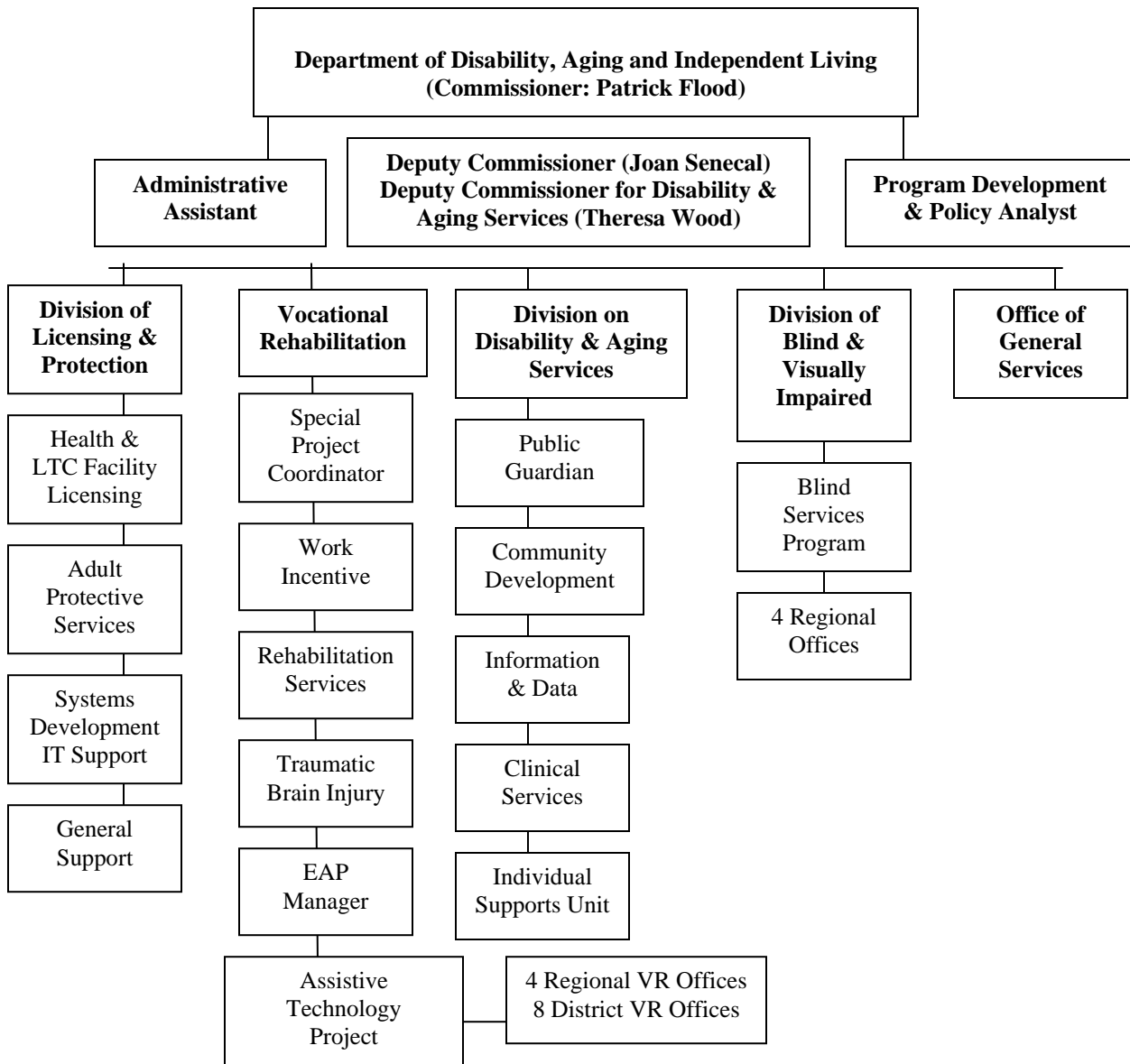


Figure 4. Organizational Chart for Vermont’s DAIL, July 2005

As Figure 4 shows, DAIL has combined licensure and protection for nursing home residents and community care participants into a single division, which includes the adult protective services program. The Division of Vocational Rehabilitation (VR) houses the traumatic brain injury waiver; and a highly innovative, multi-faceted assistive technology project, which relates to all disabilities and all kinds of technology. The VR department has the largest number of

DAIL employees, including regional and district offices, which are populated by a variety of rehabilitation counselors and specialists (including specialists for people with deafness) and which themselves have complex organizational charts. The Division for the Blind and Visually Impaired, in contrast, largely operates through contracts with community agencies and vendors and has fewer in-house staff.

The Division of Disability and Aging Services houses all the direct service programs; it is organized along functional lines rather than by age or disability type. (See Figure 5).

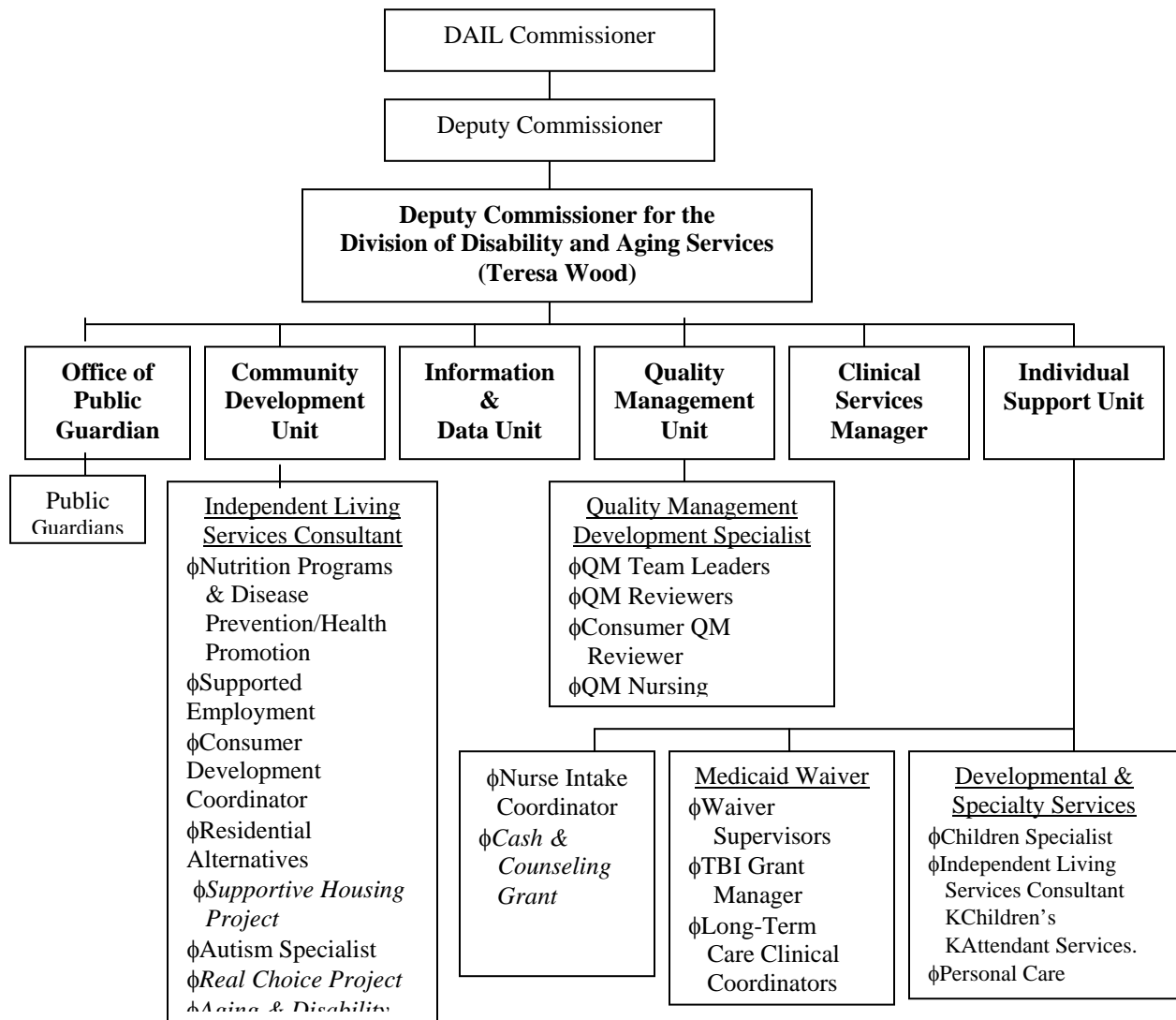


Figure 5. Dail's Division of Aging and Community Services

The Individual Support Unit includes most waiver programs, the TBI program, the developmental services programs, and the Cash and Counseling project. Also within that Division under Medicaid Waivers is a group of state-employed nurses who will perform intake in the new Choices for Care Program. Other units in the Division are dedicated to Quality Assurance, Community Development, and Public Guardians. Thus, the thrust of the organization within the Division of Disability and Aging Services and its component units (and indeed the whole of DAILS) is to integrate MR/DD within functional areas rather than permitting a Balkanized place for the concerns of MR/DD. MR/DD is integrated into the Quality Management Unit and the Community Development Unit (where, in response to a newly identified need, an Autism specialist will be located). The Real Choice Systems Change Grant and the Supportive Housing Grant that Vermont secured are also located within the Community Development Unit.

This structure, which is still in evolution, is worthy of attention because it constitutes a of the most thorough efforts to date to integrate the organization across disabilities along functional lines and to combine policy, financing, and program responsibilities—and to do so within an umbrella agency. Leaders at DAIL have commented that strengths from the DD, aging, and adult disability world can be brought together through this cross-fertilization.

In keeping with the State's vision and the Department's comprehensive roles, DAIL's goals are stated as follows:

- Assist older persons and adults with physical disabilities to live as independently as possible.
- Assist persons with disabilities to find and maintain meaningful employment.
- Assure quality of care and life to individuals receiving health care and/or long term care services from licensed or certified health care providers and protect elderly and disabled adults from abuse, neglect and exploitation.

Local Organization for LTC

Vermont is divided into 5 planning and services Areas for AAAs, shown on the map in Figure 1. The state is divided into 10 regions for the administration of waivers, it has 4 regional and 8 district Vocational Rehabilitation offices, and 8 mental health regions, the latter administered through the Department of Health. The Long-Term Care Ombudsman program is provided by Legal Aid of Vermont, which serves Vermont's counties through 5 legal aid offices throughout the state. This plethora of sub-state organizations means that assistance is not far from where any Vermonter lives.

The local service delivery structure for LTC in Vermont reflects a unique involvement of providers and advocates at an extremely local level. Leadership roles for geographic areas have been vested in home health agencies and Area Agencies on Aging for the programs for elderly and adults with physical disabilities, and in 10 Designated Agencies (DAs) for developmental services, which provide both intake and case management. To access the attendant program, the consumer applies to the Area Agency on Aging or Home Health Agency, but the actual determinations and amount of allocation are made by Committees heavily represented by persons with disabilities to determine the amount of care needed. When the Choices for Care program is initiated, the access function for community care for seniors and people with physical disabilities will become centralized, though elements of the strong local involvement will remain in service provision and case management (the waivers for developmental disability, traumatic brain injury, and children with mental illness will be unaffected). Given a long period of working on long-term care in partnership with the State, these local agencies have developed a considerable sense of community responsibility and commitment to rebalancing goals. The entry system to services is described in more detail in Section II, under *Access to Services*.

Community Long-Term Care Coalitions, a mechanism for advocates, consumers, and providers to plan at the local level were a unique feature in Vermont's development of long-term support services (See Section III for further description.) In general, the State agencies for LTC in Vermont (now 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.

Litigation Related to Rebalancing

We did not identify any current or post-Olmstead law suits in Vermont. A much earlier legal action was significant, however, in the closure of the Brandon Training School for people with developmental disabilities, which opened early in the 20th century and at its peak had about 600 residents. Although discussion of possible closure was occurring in the 1970s because of dwindling census, a suit filed by Protection and Advocacy Agency on behalf of Robert Brace and five other residents who wanted to live in the community hastened that process. The 1980 settlement, known as the Brace Decree, included a 10-year, supervised plan to move most of the then 300 remaining residents out of the institution.

During our site visit, we learned of an emerging legal matter quite different from a typical disability rights action. The Justice Department received a complaint from a for-profit agency that wanted a Certificate of Need to be a home health agency. The Complaint was that the existing home health agencies had colluded to set areas of service among themselves, and not competed, and also to fix prices. Since that time, the Vermont legislature has passed legislation confirming the current home health arrangement is the state's policy, so the investigation may be moot. Since then, as well, the Agency that wanted the Certificate of Need has received it. To the extent that geographic rationalizing and management of the system is intrinsic to Vermont's

rebalancing strategy, the outcome of this suit will be relevant. Certainly, the geographic franchising with reference both to aging and disability care and to developmental services seems to have worked and resulted in providers that are largely favorable to community care (see Service Environment discussion in this section, below).

Advocacy Environment

Consumer involvement and self-advocacy is a well-established fact in Vermont's LTC programs. Consumers have an active role in program formulation and on-going program monitoring, and many organizations conduct well-organized legislative advocacy activities. The Community of Vermont Elders (COVE), a coalition of organizations, was formed in 1980 "to promote and protect a higher quality of life for the state's seniors." Its intent is to achieve this mission through advocacy and education, helping "elder Vermonters and the organizations that serve them to identify, interpret, and respond to critical issues that impact the dignity, security and wellbeing of seniors." A broad-based advocacy organization, COVE is comprised of 40 organizations and individual members. Organizational members include area agencies on aging (which in Vermont have historically emphasized their advocacy function), senior centers, AARP, Older Women's League, professional associations, and provider organizations. COVE was a leader in the passage of legislation to develop and expand the HCBS waiver program in the late 1980s, passage of Act 160 (discussed below), and legislation approving the Choices for Care demonstration. COVE proposed language in the bill that required the state to invest savings from the demonstration into expanding services. COVE is the lead organization for receipt of a major grant for state-wide LTC labor force development.

The Vermont Protection and Advocacy organization is led by a former state legislator who served for 12 years and was a prominent member of the Health and Welfare Committee when

Act 160 was passed. The Arc of Vermont has a long history of effective advocacy. The Vermont Council Developmental Disabilities Council is a statewide organization comprised more than 50% by individuals with disabilities. Many other disability organizations are active in public policy-making in Vermont, including associations for Cerebral Palsy and for Spina Bifida, the Vermont Association for the Blind, and several active self-advocacy groups of people with mental illnesses.

In addition to consumer groups, the Vermont Council of Developmental and Mental Health Services (an organization of the lead provider and case management agencies) and the Area Agencies on Aging tend to emphasize consumer advocacy functions. As indicated, the Ombudsman Program is housed in Vermont Legal Aid, and, as one of the few Ombudsman programs nationally located outside government and in a legal agency, has a strong thrust towards disability rights. The recently released report of the Governor's Olmstead Advisory Commission is detailed, specific, and comprehensive. The new "Choices for Car" Waiver was developed with stakeholder input and DAIL Website contains a wide variety of issues and concerns raised by stakeholders, along with DAIL's responses.

In summary, advocacy is well-established in Vermont and consumer advocates are skilled and informed, and processes have been established for transparent government activity and widespread consumer involvement.

Service Provider Environment

Vermont has a moderate supply of nursing home beds, 42.6 beds per thousand people over age 65.¹² Since 2000, the number of licensed nursing facilities has dropped 7% from 54 to 50 and the number of licensed beds declined from 3,548 to 3,316, or 6.5%. Occupancy rates so far

¹² Census Bureau Population Projections July 2004 and CMS nursing home supply data December 2004 compiled by the American Health Care Association.

have remained stable at 92%-93%. Nursing home reimbursement rates are high relative to those in most states. In 2004, DAIL licensed just 1 ICF-MR and it had fewer than 6 beds. No licensed facilities licensed with more than 16 beds. (See Table 3.)

Table 3. Supply of Residential Care Settings, 2000-2004

Setting	2000		2001		2002		2003		2004	
	Fac	Beds	Fac	Beds	Fac	Beds	Fac	Beds	Fac	Beds
Nursing homes	54	3,548	54	3,617	52	3,413	51	3,396	50	3,316
ICF <16	2	12	2	12	2	12	1	6	1	6
Residential Care III	88	2,054	89	NA	94	NA	96	2,110	100	2,191
Residential Care IV	28	290	25	NA	17	NA	15	152	13	125
Assisted Living Residence	0	0	0	0	0	0	2	86	5	210
Housing & Supportive Services	0	0	28	1,164	29	1,265	29	1,265	29	1,271
Group living	14	70	15	69	13	61	14	69	15	74
Staffed group living	15	21	18	25	19	26	20	24	23	31
Unlicensed homes	721	813	704	811	758	875	796	911	828	952

Notes: Fac. stands for “facilities,” and is used for convenience for the building or program just as “beds” is used for the people served. Both terms come from the nursing home world and both poorly reflect the small residential settings in Vermont.

Vermont also licenses 2 levels of Residential Care Home where services can be provided, Assisted Living residences (since 2004), Housing and Supportive Services Settings (where services are added to existing housing), and 2 levels of Group Living, largely for developmental services. The supply of Level III Residential Care Homes, which provide a higher level of care than Level IV homes, grew from 88 facilities with 2,054 beds in 2000 to 100 facilities with 2,191 beds in 2004. Level IV homes dropped from 28 in 2000 to 13 in 2003 and the number of beds declined from 290 to 152 as several homes converted to Level IIIs. Assisted Living Residences must, by statute, beat minimum singly occupied units with full bathrooms, kitchenettes, and locking doors.¹³ In 2004, the year after Assisted Living Residences were first licensed, DAIL reported 5 licensed facilities with 210 units. From 2002 to 2004, DAIL awarded grants to 29

¹³ Mollica, R, Johnson & Lamarche, H. (2005). *Residential Care and Assisted Living Compendium 2004*. (Under grant from OASPE to Research Triangle, Inc, Submitted to ASSPE Marhc 2005). Portland, ME: National Academy for State Health Policy.

Housing and Supportive Services (HASS) sites with a total capacity to serve 1,271 in 2004. The number of sites dropped to 25 in FY 2006.

The number of individuals with developmental disabilities in group living settings ranged from 61 to 74 in 13 to 15 sites between 2000 and 2004. Individuals served in staff living arrangements grew from 21 in 2000 to 31 in 2004. Individuals are also served in unlicensed homes that meet provider contracting standards. The number of people served in this setting grew from 813 people in 721 homes in 2000 to 952 served in 828 homes in 2004.

Home health agencies and developmental services agencies are well established in Vermont. Vermont has a certificate of need law for home health agencies. The state has approved 13 home health agencies. The for-profit agency was awarded a certificate of need in August to provide services statewide. Each agency has serves a distinct geographic region. As indicated, the U.S. Department of Justice is currently investigating the state's contracting practices. Officials representing home health agencies speculated that one agency may be approved to serve the entire state rather than being confined to a geographic area. Home Health Association officials described staffing as a significant challenge; given long travel distances and the need to find back up workers when the primary worker is sick. Further expansion of community services may exacerbate the shortage. Home health agencies recruit workers continuously and have difficulty finding workers who will work odd hours, although they state that they advertise continuously. Most agencies offer fringe benefits, including sick leave, vacation time and some provide health insurance for staff that are available full time. Retirement benefits are also available. Some concerns have been expressed about attracting and retaining qualified personnel for long-term care programs, and a special labor force initiative has been undertaken on that issue. Home care providers described difficulty recruiting workers for nights and weekends, and

some condition health insurance coverage to full-time workers willing to work on alternative weekends. Others set a number of hours that must be worked to earn sick leave and vacation time. Personal care attendants earned an average of \$9.21 an hour in 2004. Independent providers are paid an average of \$10 an hour but do not receive benefits.

In general Vermont has a good capacity to deliver a wide range of long-term care services. State officials have identified day care as an area requiring expansion of supply.

Historical Evolution of LTC

Vermont's recent history is punctuated with efforts to develop an innovative, community-based, consumer-centered system, maximizing the use of state resources and building on federal resources as possible. Table 4 shows historical milestones of planning and program initiation; it also includes the initiation of some projects funded by external grants; Vermont has made strategic use of grants from CMS, AOA, other government agencies and Foundations strategically over the last 20 years.

The waiver for Developmental Disability was approved in 1982 for a start in January 1983 (which was the earliest possible time), and the Attendant Services Program initiated the following year. The waiver for seniors and older people with disabilities was approved in 1987, and in the 1990s, waivers were approved for traumatic brain injury, assisted living/residential care, and children under age 22 with mental illness. Regarding grant-funded project, Vermont has competed successfully for many Real Choice System Change grants as shown in the table, culminating in 2004 when Vermont was one of 2 states awarded a Comprehensive System Reform grant for \$2.1 million. Significant Foundation grants include the Coming Home grant for affordable assisted living, the statewide workforce development project funded through Better Jobs, Better Care, and a second-generation Cash and Counseling project. The System

Assessment section will illustrate how well these grants were used in tandem as vehicles for comprehensive system planning and development.

Table 4. Selected LTC Milestones in the State of Vermont

Year	Policy or Programmatic Development
1982	HCBS waiver for MR/DD approved (enrollment began in 1983)
1983	Participant-Directed Attendant Services program established for people with physical disabilities
1987	HCBS waiver for older adults and people with disabilities approved
1989	Department of Aging Disabilities (DAD) established
1991	DAD issues Long Term Care in Vermont report for Rebalancing DAD initiates pilot program for individuals with traumatic brain injuries
1993	State closes its only institution for persons with developmental disabilities Vermont Health Care Authority issues report on Long Term Care recommendations for state LTC insurance CAILS process began under AOA grant. Recommendations for Meeting Vermonters' Needs Into the 21st Century that proposed a social insurance model
1996	Act 160 authorizing: reduction in the Medicaid nursing home census and transferred funds for HCBS programs; expanding the Department's authority for coordinating policy across programs; establishing a comprehensive database to track caseloads and expenditures across programs Assisted living/residential care facilities waiver implemented Legislature passed Development Disability Act of 1996
1998	HCBS waiver for children under age 22 with mental illness approved
1999	Legislature passes developmental disabilities act. One-to-One: A Nursing Home Transition Grant program.
2001	Real Choice Systems Change grant approved. RWJF Coming Home grant for affordable assisted living.
2002	HCBS waiver for people with traumatic brain injuries approved
2004	Agency reorganization transferred DD and children's personal care services to a new Department of Aging and Independent Living RCSC Grant: Integration of LTC with affordable housing. RCSC Grant: Quality Assurance RCSC Grant: Comprehensive System Reform(about \$2.9 million) Cash and counseling program from RWJF. Better Jobs, Better Care Award from RWJF and Institute for Future of Aging
2005	Section 1115 "Choices for Care" long term care waiver demonstration approved. RCSC grant: ADRC

On the legislative and policy front, the following milestones are significant:

- In 1991 the Department of Aging and Disability (DAD) developed a report that set the first goal to balance the system by spending 30 percent of long term care funds on HCBS.
- Using a grant from the U.S. Administration on Aging, DAD worked with heavy stakeholder involvement to design a system that supported independent living, called Community Assisted Independent Living System (CAILS). The design included regional service centers or single entry points to reduce fragmentation and facilitate access to

information, assistance and services. The CAILS initiative collapsed because of conflicts among stakeholders over which organizations would function as a regional center, and lack of funding. The process, however, engaged stakeholders in considering the design of system building blocks like assessment, case management, and data infrastructure. This exercise aired the values inherent in the attendant program, the developmental services programs, and the aging network programs.¹⁴

- In 1993, the Vermont Health Care Authority proposed a social insurance program to address the health and LTC needs of Vermonters.¹⁵ For LTC, the state would have raised its income tax by 0.7% and placed the revenues in a trust fund. Coverage would be earned based on the length of time a person contributed to the trust fund. Benefits were capped at a daily rate and could be used in the community or in a nursing home. The social insurance proposal passed the House of Representatives but did not pass the Senate.
- Act 160, passed in 1996, directed DAD to reduce nursing home spending in FY 1997 through FY 2000. The reductions required a drop in the Medicaid census of 46 beds in FY 1997; 68 beds in FY 1998; 59 beds in FY 1999; and 61 beds in FY 2000. The Act gave the Secretary of Human Services the authority to reduce the supply of nursing homes. More detail on Act 160 is provided in Section III.
- In 2005, the 1115 waiver for Choices for Care was approved and a dramatically new approach to the management of nursing home and waiver services for elders and adults with physical disabilities was initiated in October 2005. The plans for this demonstration are described in Section III.

Programs and Services

Medicaid Waivers

From 1983 to 2002, Vermont developed five Medicaid waiver programs, summarized in Table 6. Waiting lists are occasional and minimal; for example, 9 people appear to be waiting now for the Developmental Disability Waiver. The HCBS waiver and the Enhanced Residential Care Waiver are subsumed in the Choices for Care demonstration and lose their identity, whereas the others will continue.

¹⁴ Reinardy, J, Kane, RA, & Mollica, RL (1994). CAILS Assessment Project: Background Data. (Submitted to Vermont Department on Aging and Disabilities, September 15, 1994). Minneapolis, MN: University of Minnesota Long-Term Care Resource Center. Also many of these developments are summarized in Justice, D (2003). Promising Practices in Long Term Care Systems Reform: Vermont's Home and Community Based Service System. Washington, DC: Medstat.. Available at http://www.hcbs.org/files/44/2199/VT_final.doc.

¹⁵ Vermont Health Care Authority. Long-Term Care: Recommendations fro Meeting Vermonter's Needs into the 21st Century. Montpelier, VT. November 1, 1993.

Table 5. Summary of Medicaid Waivers.

Waiver (and eligibility)	Date begun	Enrollees in 2004	Services
Developmental Disability	1983	1,961	Service planning and coordination; community supports; employment services; respite; clinical interventions; consultation, education & advocacy; crisis services; housing and home supports (supervised living, staffed living, group living, home providers); transportation; partial hospitalization and day services.
HCBS (Seniors and younger adults with disabilities with nursing-home level needs)	1987	1,729	Personal care, adult day services, respite, case management, assistive devices, and home modification. Since 1998, participants or their surrogates could elect a self-directed option.
Enhanced Residential Care (Same target as HCBS waiver but for people living in licensed residential care or assisted living.)	1996	256	Nursing overview (assessment, oversight, monitoring, and routine tasks), personal care services, case management, medication assistance, recreational and social activities, support for individuals with cognitive impairments, and 24-hour, on-site supervision.
Children with Mental Illness (under age 22)	1998	122	case management, family education, clinical assessment, individual/family/group therapy, psychiatric services, crisis assessment & support; home health, habilitation, respite, in-home support, foster care
Traumatic Brain Injury (16 + with recent moderate to severe brain injury that results in residual deficits and disability and requires one-to-one instruction on independent living skills.)	2002	54	Case management, rehabilitation services, community supports, environmental and assistive technology, crisis support, respite services, psychology and counseling support, and employment supports.

Developmental Disabilities Waiver. This is the earliest and largest waiver. The target is people with developmental disabilities and mental retardation; the waiver served 1,961 participants in FY 2004. The DD waiver accounts for over 96% of all funding for consumers with developmental disabilities.¹⁶ The waiver covers service planning and coordination; community supports; employment services; respite; clinical interventions; consultation, education & advocacy; crisis services; housing and home supports (supervised living, staffed living, group living, home providers); transportation; partial hospitalization and day services. Consumers may receive supports through the waiver and the state plan personal care program.

¹⁶ Division of Developmental Services. Annual Report 2005.

Since December 2001, the program has not served new children under waiver unless they are returning home from an out of state institution. At the end of FY 2004, 65 on the waiting list received services. By November, 2004, there were nine individuals waiting for services.

Home & Community Based Services Medicaid Waiver. The Home and Community Based Services Waiver serves older adults and adults with physical disability. It covers care, adult day services, respite, case management, assistive devices, and home modification. The waiver was approved by CMS in 1987 and serves about 1,300 participants in October 2005. Since FY 1998, participants or their surrogates have had the option to direct their care and serve as the employer who recruits, hires, trains, and supervises the care provider. A fiscal agent is responsible for the payroll, withholding and related functions.

Enhanced Residential Care Waiver. This waiver, implemented in 1996, serves beneficiaries living in licensed residential care and assisted living residences. DAIL uses a three tiered payment system based on scores in five areas: ADLs, bladder and bowel control, cognitive and behavior status, medication administration, and special programs (behavior management, skin treatment, or rehabilitation/ restorative care). The rates are: Tier I (\$42.00 a day); Tier II (\$48.50 a day); and Tier III (\$55.00 a day) and are on top of room and board plus ACCS rates, so that the total daily payment for someone in ERC is over \$100 per day. Room and board is limited to the Federal SSI benefit and beneficiaries receive \$47.76 for personal needs.

TBI waiver. Through the Division of Vocational Rehabilitation, DAIL administers a Traumatic Brain Injury (TBI) waiver for people age 16 or older who have a recent moderate to severe brain injury that results in residual deficits and disability and requires one-to-one instruction on independent living skills. This waiver will not be affected by the new program.

Children with mental illness waiver. Vermont is one of only 4 states to have an HCBS waiver for children with mental illness. Children under 22 eligible for this waiver must be assessed as unable to be helped with less than hospital level care; the Child Behavioral Checklist is used in assessment. The waiver provides a wide range of intensive clinical services close the child's home. Costs are compared to inpatient costs in psychiatric units in Vermont hospitals. In 2004, 179 children were served in psychiatric hospitals at a cost per day of \$1200, an average length of stay of 9.2 days, an average daily census of 5, and total annual costs of \$438,000. In contrast, 122 children were served in the waiver at a cost of \$156 per day, an average length of stay of 14 months, and average daily census of 110, and total annual costs of \$57,000.¹⁷

State Plan and State-Funded Services

Assistive Community Care Services. Assistive Community Care Services (ACCS) is a Medicaid state plan service for beneficiaries living in Level III residential care facilities or assisted living residences. Facilities receive a daily rate of \$30.25 to provide nursing overview, personal care, health, rehabilitative and supportive services. The program was financed by shifting state resources from the SSI state supplement to match Medicaid expenditures. The state's SSI supplement was increased after 1983 and federal rules allow states to reduce the supplement to the level in effect prior to 1983.

Adult Day Services. Adult day services are funded by the Medicaid HCBS waiver, the Medicaid state plan, general revenues and SSBG funds. It covers health assessment, screening and monitoring, therapies, personal care and nursing services.

¹⁷ Pierce, J. (2004). Vermont's Home and Community Based Waiver for Children's Mental Health Services. Presented at a Medicaid and Mental Health Pre-Conference, Mental Health & Substance Abuse Conference, National Conference of State Legislatures, December 7-8, 2004. Slides on website at: http://www.ncsl.org/programs/health/mentalhealth_FF04presentations.htm

Attendant Services . Participated-Directed Attendant Care (PDAC) is 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. Spouses and civil union partners may not be paid to provide attendant services. Attendant services serve elders and adults with physical disabilities who need assistance with activities of daily living. Attendant services are also funded under the state general fund. People who have a disability and need physical assistance with at least ADL or meal preparation and are Medicaid beneficiaries may qualify for general fund personal services. Spouses or civil union partners may be paid only under the state or general fund part of the Attendant Services Program to provide attendant services.

Homemaker Services. The Homemaker Program is funded by general revenues and the Social Services Block Grant. It serves elders and adults with physical disabilities who assistance with one or more activities of daily living and/or have a cognitive impairment. The program covers professional or personal services, including homemaker services required on a recurring or continuous basis because of physical or mental impairment.

Housing and Supportive Services . The Housing and Supportive Services (HASS) Program uses state general revenues to coordinate access to existing community services for older adults and adults with physical disabilities who living in congregate housing settings. Besides service coordination, program funds can be used to finance supports that are not available for residents who are at the greatest risk of nursing home admission. HASS allows residents to age in place and avoid or delay admission to other settings. In 2005, 24 sites participated in the program, which served over 1,000 residents.

Flexible Family Funding. A flexible family funding program is funded by state general funds and provides up to \$1,122 a year for consumers with DD of any age who live at home with

their family. Seventy percent (70%) of the 808 individuals served in FY 2004 were children. State officials indicated that self-advocates prefer that parents are not paid as caregivers in this program in order to promote and support the consumer's independence.

Personal care. Children's Personal Care is available under the Medicaid state plan as an EPSDT service. The program supports an average of 25 hours week of personal supports to participants. Participants receive individual support to assist with ADLs and enhance skill building to advance their ability to live independently. Services may be agency based or consumer directed.

Section II. System Assessment

In this section, we briefly profile selected system functions, using identical headings to those in each state-specific case study. The section that follows details selected Vermont's programs or initiatives that are especially noteworthy or innovative management approaches for rebalancing.

Access to Services

Consumer Information

AHS and DAIL offer a wide 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, which is profiled in Section III.¹⁸ These Internet Tools are particularly clear, and can be used not only directly by consumers, but also by those who provide advice and case management. The extent to which information is a barrier to access is not known, but access should be enhanced by web tools, informational brochures, and by the plethora of regional and district offices.

¹⁸ Available at <http://screendoor.vermont.gov>.

Access to Services

Staff from Vermont Office of Health Access determine Medicaid eligibility, and staff from the Division of Children and Families determine financial eligibility. The initial assessment and access to long-term care services has been managed through a system of regional Designated Administrative Agencies (DAAs) for seniors and adults with physical disabilities and Designated Agencies (DAs) for developmental services.

Aging and adults with disabilities. Prior to 1997, for the elderly and disabled Waiver, applicants were served on a first come, first served basis. State officials and local stakeholders felt the system did not allocate resources equitably based on the needs of applicants. In a new process, implemented in 1997, consumers completed and submitted an application to the DAA and selected a case management agency. The case management agency completed a priority assessment within seven days to determine a priority score. The assessment and priority is reviewed by the waiver team and allocate a waiver slot to applicants that meet the priority if one is available. There were four priority categories:

- Applicant lives in a nursing home and need waiver services to return to the community;
- Applicant is in a hospital and will be admitted to a nursing home unless waiver services are provided;
- Applicant lives at home or in a residential care facility and will be provided and has a score of 50 or greater; or
- Applicant lives at home or in a residential care facility and will be provided and has a score between 40-49.

In 5 regions, the AAA was the DAA and in 5 the home health agency was the DAA, but in practice they worked closely together. (In Vermont, nonprofit home health agencies each operate in a geographically designated catchment area and are intrinsic to the program). The DAA in each region was designated to perform administrative tasks associated with the waivers, including the following: managing the initial application process; facilitating Medicaid Waiver

Team(s); reviewing Medicaid admissions to nursing homes; and publicity and outreach regarding waiver services; although AAA and home health agency may do an initial assessment together, only the DAA may bill for that function.

The DAAs complete an initial screen to determine whether the applicant is likely to be eligible for the HCBS waiver. A 'Waiver Team', which includes a financial eligibility specialist from Children and Families (which is responsible for Medicaid financial eligibility decisions), hospital discharge planner, Area Agency on Agency, Home Health Agency, Adult Day Services provider, and a mental health clinician, reviews the individual's priority score and decides which of the pending applicants will receive the next available waiver slot. Stakeholders indicated that the process worked very well. Local teams know the applicants and reach consensus quickly. Team members also devised plans to stabilize applicants while they waited for an HCBS waiver slot to become available. Approved applicants then select either the home health agency or the AAA as their case management provider. Once the consumer is approved for a waiver slot, the case manager completed a full assessment and plan of care within 14 days. The assessment and plan of care was reviewed by DAIL staff to approve the level of care determination, verify financial eligibility, authorize the initial plan of care and send the approval to the DAA. Case managers were required to contact consumers at least monthly and visit at least once every 60 days.

The teams meet monthly or more often as needed and are chaired by the DAA. Team members do not receive payment for attending meetings. Stakeholders indicated that they attend to maintain good connections to the service network. Staff from the DAAs said their leadership balances the self-interest of other provider members.

The system did not provide for preadmission screening for individuals seeking admission to a nursing home. Waiver participants who enter a nursing home did receive follow up visits from case managers to develop discharge plans when possible. However, AAA case managers were not automatically contacted when one of their clients is admitted to a nursing home or a hospital.

This system will be modified in Choices for Care so that initial assessments for eligibility nursing homes or the 2 waivers serving elderly and adults with disabilities will be conducted by state-employed registered nurses who will be co-located with state eligibility workers. The co-location is meant to streamline and speed the financial eligibility process, and the state-employed nurses is meant to bring statewide consistency in the front-end assessments for the levels of need under the 1115 waiver described below. The home health agencies and Area Agencies on Aging will then assume their case management roles.

Developmental services. A somewhat parallel structure is use for accessing MR/DD services. The Division of Disability and Aging Services contracts with 10 Designated Agencies (DAs), one in each region of the state to plan, coordinate and monitor services for individuals with developmental disabilities. Services are provided by DAs directly or through contracts with other organizations or individuals. DAs manage the intake and referral process, conduct assessments, establish an amount of money that can be authorized, develop support plans, provide regional crisis responses and generally ensure that sufficient provider capacity exists in their region to deliver authorized services. DDS also contracts with a four Specialized Service Agencies (SSAs). These organizations offer a distinct approach to service delivery or meet unique individual needs. One of the SSAs was formed by parents to provide supports to help consumers avoid entering the Brandon Training School. Unlike DAs, SSAs services areas are more limited and they are not required to serve the entire county in which they are located.

Waiting lists. Waiting lists are reported each month to DAIL and entered into a spreadsheet by county. Before the Choices for Care Demonstration, about 100 people were waiting for waiver services. The central data base allowed new resources to be allocated equitably across the state. Once funds are allocated, they remain with the region unless a person leaves the waiver program and there is no waiting list in the county.

DAIL has the flexibility to approve waiver slots in an emergency. Each month DAIL officials track cash outlays for waiver services and nursing home care compared to spending projections. If there is a reduction in nursing home spending, funds may be approved for additional waiver slots.

Access to other programs. Consumers who apply for the TBI waiver, the homemaker services program and the attendant care programs are referred to DAIL staff by a range of provider and community organizations. Eligibility and assessments for these different services are done differently. Homemaker assessments are done by the Home Health Agencies. Attendant Services assessments have been done by state staff, but of course, the participants hire their own attendants. Once approved, applicants are referred to the provider agency of their choice.

Array of Services

Vermont covers an exceptionally wide array of services for elders, adults with physical disabilities and individuals with developmental disabilities. Community services include consumer-directed and agency home care and personal care, a range of habilitative services, and group residential services.

Services for elders and adults with physical disabilities are covered by multiple sources. Services covered by the Elderly and Adults HCBS waiver and the Enhanced Residential Care

waiver are now part of the Choices for Care demonstration. Medicaid state plan services and services funded by state general revenues will continue to operate as separate programs. The services covered by the Developmental Disabilities Services waiver are not immediately included in the demonstration. A decision about including DDS waiver services will be made when the waiver is renewed in 2007.

Quality Approaches

Quality assurance efforts of DAILs include periodic and systematic consumer satisfaction surveys. From the late 1990s, one division of DAIL began contracting with the ORC Macro firm to conduct mailed and telephone surveys of elderly and physically disabled consumers to get feedback across regions and programs. The survey conducted in 2002 was particularly comprehensive, and included measures of quality of life; among the elements summarized by geographic region were: satisfaction with social life and connection to the community; concern about financial security; perception of being valued and respected; and concern about someday needing to go to a nursing home.¹⁹

The Quality Plan envisaged for the Choices for Care demonstration, described in the Operational Protocol for the demonstration, includes consumer satisfaction surveys; review and approval of all plans care; desk monitoring activities by DAIL staff; tracking delivery to authorized services; on site provider surveys; face-to-face visits with consumers; and case manager certification. A set of quality indicators was developed for providers. Central office staff will periodically review level of care assessments and decisions made by regional staff. The process will encompass a review of all documents to completeness, a review of the health and functional information, the proposed service plan.

¹⁹ RC Macro (2003). 2002 Consumer Satisfaction Survey. (Submitted to Vermont Department of Aging and Disabilities, June 30, 2003). Burlington, Vt: ORC Macro.

DAIL will continue to conduct annual consumer satisfaction surveys of Choices for Care participants as well participants receiving adult day services, attendant services and homemaker services. All plans of care will be reviewed and approved by DAIL staff.

In Vermont, case management is an important source of oversight and quality assurance. Case managers must be certified and receive 20 hours of education or training annually.

Consumer Direction

HCBS waiver participants (both those using programs for aging and adults with physical disabilities and those using developmental services) may choose between agencies or consumer directed services. For elders and adults with physical disabilities, consumers or a surrogate are allowed to direct personal care, and a maximum of 720 hours a year of respite care and companion services under the waiver. About half of the participants choose the consumer directed model. A case manager reviews the consumer's cognitive and communication ability to act as an employer. The case manager and the consumer complete a personal care worksheet and plan of care. The personal care worksheet describes the specific tasks and services that shall be provided for the individual. The Plan of Care identifies the type and amount of services that has been approved. These documents are used by the consumer to plan service schedules and approve timesheets. A single fiscal intermediary is used to process payroll.

The Participant-Directed Attendant Program, described in Section III, also reflects consumer direction and consumer participation at the planning level as well. Although consumer direction has been a feature in Vermont for a decade, Vermont ways to further empower consumers in the Cash and Counseling program, which it is about to initiate.

Institutional Downsizing

We did not identify particular strategies in the payment and monitoring of nursing homes that were designed to shrink or re-direct the industry. Rather Vermont is proceeding through targeted goals and the ability to move money to meet consumer needs. Choices for Care should result in a downsized nursing home industry. Bill 543 (Act 56), which established the Choices for Care demonstration, also called for a task force to develop statewide recommendations on the future of nursing homes in Vermont, including the Vermont Veterans Home. The recommendations were to address:

. . . the transition issues for nursing homes as more individuals use home-and-community-based long-term care services, how nursing homes can convert the services offered to provide long-term care services differently, unmet needs for nursing home services for individuals, accessibility for individuals with disabilities in nursing homes, and the methods which nursing homes can use to become more resident-centered in the provision of long-term care.²⁰

The recommendations that come out of this task force, which by statute must include long-term care consumers and providers, will be of great interest.

Data Capacity

Reporting on services and costs within programs was part of the requirements of Act 160, and DAIL has been able to generate those reports. DAIL is conscious of the need for data to inform its planning and oversight, and data specialists are liberally scattered through the various DAIL units. To develop an overall picture for this case study, we used 3 data systems: MMIS (which is largely the Medicaid data system), "DAILCARE," and "SAMS." MMIS includes information about aging and developmental services institution/waiver clients, but aging and DS clients are tracked differently. Expenditures and client demographics are available from this

²⁰ A synopsis of House Bill 543 (Act 56) of the Vermont Assembly, which created the 1115 waiver plan, is available on the web at: <http://www.nashia.org/newstate/2005/VT%20HB%20543.doc>
Last visited October 24, 2005.

setting. DAILCARE and SAMS are exclusively for aging and physically disabled adult consumers, but the intention is that both target groups will be incorporated into these systems in the future. DAILCARE (an Access-based database) is for any client with an independent living assessment (which essentially means anyone in a waiver program). The DAILCARE system tracks inputs, such as plans of care (assessments and re-evaluations) and services that have been approved for the client. Nursing home clients are excluded from DAILCARE. SAMS, on the other hand, is a SQL relational database and tracks service/program use of all DAILCARE cases; SAMS data include frequency, hours, and ADLs. While SAMS and DAILCARE are for the same population (and therefore linkable), the linkage between MMIS and the other two is currently not as easy. But analyses across the three data systems are feasible and are conducted for DAIL customized reports. Data analysts in Vermont anticipated that SAMS/DAILCARE should be one system in the future. In summary, Vermont offers a solid data system foundation, but future steps will require further synthesizing of aging and developmental services data and further coordinating the individual system components.

Mental Health Linkages

Mental health specialists have been part of teams at the local level, and a comprehensive mental health services network is established throughout the state. The emphasis over the past 20 years has been to bring the full range of clinical services to local communities. Vermont State Hospital (VHS), which served 1,350 citizens at its peak, has been averaging a census under 50 in recent years. With its downsizing and the attention to community care, VHS has come under a quality cloud. With several suicides and being off-and-on decertified in a 2-year period, it was at the receiving end of a scathing report from the U.S. Department of Justice in July 2005 on what it called inhumane and unsafe conditions at the hospital. On the basis of medication errors and

misdiagnoses, the report alleged violation of civil rights of the patients. The Department of Health currently must address the comments. An active Futures Committee was established and a proposal has been outlined for meeting the needs presently met at VHS through augmented community care with diversion beds and smaller in-patient units linked to acute hospitals.²¹ The Vermont chapter of the National Alliance for the Mentally Ill is on record with the view that the solution must be a more coordinated approach to treating people who have mental health diagnoses or labels and to “ensure that people receive less intrusive services in their community, rather than letting people become a danger to themselves and others and forced into VSH.”

Mental health authorities are concerned about a high suicide rate in Vermont, including suicide among children. With the current placement of mental health programs in the Department of Health, the intent is to develop vigorous mental health services. In 2005, Vermont received a SAMSA \$3 million, 5-year grant for Mental Health Systems Transformation, and launched its strategic plan called Building Bridges.

Acute Care Linkages

Vermont has been progressive in its Medicaid program coverage, including its Separate Child Health Program (SCHIP). Additionally and importantly, Vermont has the explicit policy goal of integrating the delivery of acute and long-term care services in ways that will make services more effective. The Vermont Independence Project began a “Care Partners” project in 2001, which involved case managers from Area Agencies on Aging working part time in the offices of nine primary care providers in 3 counties.

Vermont was one of 11 states, which availed itself of funds from the National PACE Association (through a Hartford Foundation Grant) to develop and administer additional PACE

²¹ Smith, C (2005). Recommendations for the Future of Services Provided at the Vermont State Hospital: Strengthening the Continuum of Care for Vermonters with Mental Illness., Report issues on February 4, 2005.

sites. The population dually eligible for Medicare and Medicaid in Vermont was estimate at a little over 30,000 in 2004, and the Office of Vermont Health Access (the Medicaid Agency), accordingly, needed to evolve a program suited to the rural area and small population size. PACE development proceeded with extensive state involvement, using the Long-Term Care Coalitions created under Act 160 as a focal point (see Section III). The State hired a PACE coordinator, in July 2002 held a bidders conference for prospective PACE sites, and invited Long-Term Care Coalitions to propose PACE sponsorship. Out of that two Coalitions in Chittenden/Southern Grand Isles counties and in Rutland County were selected to explore PACE. In December 2003, PACE, Vermont Inc, was incorporated as a single PACE program with two centers, and the legislature appropriated \$100, 000 to continue planning—a sum of \$200,000 with the federal match.

In the fall of 2004, Vermont was awarded a large Real Choice System Change Grant of more than \$2 million under the category of Comprehensive Systems Reform. The scope of that activity is to re-design a system in Vermont to coordinate both primary/acute and long-term care services for elderly and physically disabled adults, building on the co-case management in physician's offices and the PACE planning already accomplished; and to undertake strategies to integrate funding streams for Medicaid, commercial health insurance, and Medicaid to that end.

Housing Linkages

Vermont has had longstanding activity in integrating housing with supportive services, leading to its HASS (Housing and Supportive Services) sites, and the efforts were continued and accelerated in the early 21st century with strategic use of grants. The Vermont Housing and Urban Development Office noted in its plan for 2000-2004 that 2, 000 affordable units of senior could be identified, but that most lacked support services. Also needed were viable small-scale

assisted living models (with 20 or fewer occupants) for rural communities. Under the Robert Wood Johnson Foundation's Coming Home project grant, Vermont developed a model of affordable assisted living under the sponsorship of Cathedral Square Senior Living in Burlington, an independent living complex that received a HUD Assisted Living Conversion award. In 2004, Vermont received a Real Choice Systems Change Grant for \$900,000 under the category of "Integrating Long-Term Supports with Affordable Housing, under which it set out (among many objectives) to document resources throughout Vermont; preserve, develop, and enhance supportive housing projects; establish medication assistance practices to support aging in place in unlicensed congregate settings, and determine the viability to co-locate two PACE sites with affordable housing. The Cathedral Square Corporation, under contract to DAIL, provides leadership and consultation to the housing network. A medication pilot is planned as part of this effort.

Section III. Featured Management Approaches

Act 160 and Rebalancing Target Setting

Act 160 was perhaps the most significant step in Vermont's movement toward a balanced system. The law directed the Department on Aging and Disabilities to reduce nursing home spending in FY 1997 through FY 2000. The reductions required a drop in the Medicaid census of 46 beds in FY 1997; 68 beds in FY 1998; 59 beds in FY 1999; and 61 beds in FY 2000. The Act gave the Secretary of Human Services the authority to reduce the supply of nursing homes

.....if it 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 also 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 home and community based services or for mechanisms that reduce the number of nursing home beds Funds were used for services provided through the HCBS waiver, TBI waiver, residential care homes waiver, attendant services program, homemaker services program, Older Americans Act services, adult day care and the Vermont Independence Fund. Pilot projects to recruit and train volunteer respite care providers to provide support to family caregivers of individuals who have Alzheimer's disease or related disorders and live in rural areas of the state were also authorized.

The law gave priority to 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. The Act also included other reform provisions that directed the Department to:

- Create a comprehensive data system that tracks long term care expenditures, services, consumer profiles and consumer preferences.
- Implement a system of statewide long term care service coordination and case management to minimize administrative costs, improve access to services and minimize obstacles to the delivery of long term care services to people in need.
- Include consumer participation and oversight at the state and local levels in the planning and delivery of long term care services.
- Develop long term care service models that are alternatives to nursing home models, provided that the alternative models are comparable in cost or more cost effective than the nursing home models which provide equivalent services.

Act 160 enabled DAIL to create 685 additional HCBS Waiver slots; increase rates to Adult Day Centers, facilitating the development of increased capacity; increase the rates to personal care attendants; develop and support 10 community Long-Term Care Coalitions; reduce the waiting list for the Attendant Services Program; raise case management rates; develop and

support the Housing and Supportive Services program in congregate housing settings; raise rates in the Enhanced Residential Care Waiver; provide flexible funds to fill critical service gaps not covered by other programs; and increase the funding for home modifications by \$100,000.

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. Actual implementation in any given year will depend on the State’s fiscal situation and assumes that Federal/State Medicaid programs remain relatively unchanged.”²² The 2004 report updated an earlier report - Future of Long Term Care 2000-2010. Table 6 illustrates the specificity with which goals are monitored. The update noted that many of the recommendations still remain “works in progress.”

The report notes that while the state needs a better balance between the number of nursing home beds and the number of people served in community settings that funds would be available to support the growth of services to people in community settings from savings in nursing home spending. However, additional sources of money were needed in order to raise caregiver wages, fund new infrastructure for adult day programs, and develop new housing options.

Community Long Term Care Coalitions

Community Long-Term Care Coalitions were a unique Vermont phenomenon, associated with Act 160. 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, each comprised of representatives from home health agencies, area agencies on aging, adult day services programs, hospitals, nursing homes, and

²² Julie Wasserman. Long Term Care and Independent Living: 2003-2013. Department of Disabilities, Aging and Independent Living. Waterbury, VT. January 2004.

other service providers. Coalition members included consumers, providers, advocates and other stakeholders. Coalitions developed business plans which were reviewed and approved by DAIL that described their goals, indicators of progress, and a budget. Coalitions were supported with state funds from Act 160 and other local sources. Their charge was to review local needs and work with DAIL to improve coordination. In addition, each Coalition received additional funds to fill service gaps that meet local needs.

Table 6. Status of Recommendations from 2000-2001, Viewed in 2004

Recommendation	Status
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.	Update this target annually based on utilization and projected need. Five of 12 counties have met or exceeded this target.
Increase Home and Community-Based Medicaid Waiver slots by 100 each year and continue to allocate them to people in greatest need.	Due to budget constraints, only 54 slots were allocated in FY 2003 and 88 in FY 2004. 73 slots are expected in FY 2005.
Increase the Attendant Services Program to serve an additional 100 people by 2010.	Growth was slower than expected, having risen from 250 clients in FY 2000 to 261 in FY 2003 and FY 2004. Funds were obtained to support an increase in the number of participant hours. To maintain the 2003 rate of use, while keeping pace with demographics, the program would have to serve 58 more clients per year by 2013 (i.e., 319 clients in 2013).
As funds permit, 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.	The only program with a starting wage of \$10/hour is the Consumer or Surrogate Directed Option in the HCBS waiver. Progress in 2004 was hampered by budget constraints.
Increase the capacity of adult day centers to serve 1,500 people in 2010, up from 800 in 2000. This reflects an increase in daily capacity from 441 to 720.	Daily capacity has grown to 584 in FY 2004 with expected growth to 989 by 2014 Adult day services will expand as a result of the Choices for Care Demonstration.
Develop additional supportive housing such as Enhanced Residential Care, Assisted Living, group-directed congregate housing, and adult family care. Increase funding for home modification. Continue to promote universal design in all new housing construction.	Enhanced Residential Care and Assisted Living have expanded. Funding for home modification is increasingly inadequate. Promotion of universal design is in progress. Five assisted living residences are licensed.
Expand the Homemaker Program to serve 1,300 people by the year 2010. In 2000, this program served 700 people.	Due to budget constraints and increased costs per client, the Homemaker Program served 614 people 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 by 2013 (i.e., 1,018 clients in 2013).

Source, Wasserman, 2004.

Community coalitions were successful in enhancing case management, developing volunteer caregiver registries, training personal care attendants, expanding adult day services, expanding home-delivered meals, and informing physicians and the public about long term care service options. The Coalitions used the funds for personal care, respite, homemaking, adult day, weatherization and repairs, home modifications, financial assistance, personal emergency response systems, transportation, adaptive equipment, dentures, hearing aides, and medications. As noted above, the Coalitions were also the focal point for planning PACE projects.

A number of Coalitions still exist with varying levels of activity as funds from Act 160 have diminished. One of the Coalitions, which received a foundation grant to continue operating, designed a study circle model that involved caregivers, consumers, providers, and others in developing a plan to implement five goals: increase community awareness about aging; help people access services and ways to improve the process; improve care providers and support for caregivers; examine the range of housing and other service options and improve care coordination between hospital, nursing homes, and home health agencies.

Choices for Care: A Section 1115 Waiver Demonstration Program

Overview of Goals

The *Choices for Care* demonstration program was implemented in October 2005. It is expected to expand the long term care choices available to elders and adults with physical disabilities while contending with limited resources. The underlying problem addressed is the often noted 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 creates an entitlement HCBS services for participants who meet specified criteria. It also allows consumers who choose HCBS will to exempt up to \$10,000 in resources, which

will expand access to Medicaid for beneficiaries who live in community settings. The exemption will be phased in during the demonstration.

The program 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 global budget. The primary goals of the demonstration are to provide equal access to nursing facility and HCBS and to promote early intervention for at-risk populations. The Demonstration is will test the hypothesis that targeted early interventions, assessment, case management and the provision of home and community based services to frail elders and adults with physical disabilities will:

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

Eligibility for 3 Needs-Level Groups

Funding is capped under a global budget. DAIL will create three groups of beneficiaries under the demonstration. The *Highest Need* group will be entitled to either nursing facility or HCBS, and will have an entitlement to the service. 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, called the *High Needs* group will be served as funds are available. This group will meet the existing level of care threshold for nursing home care and the HCBS waiver, but they will not automatically be entitled to services. At the outset DAIL estimates that approximately 3,400 persons will be served, 2,200 in nursing homes and 1,200 in

community based services. Because of the expected shift in consumer choice from nursing home to HCBS and the resulting savings, DAIL expects to serve all applicants who qualify for the high needs group. Existing HCBS participants will continue to be served. 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.

Table 7 shows the criteria for each level of need. We labeled functional criteria as “A,” cognitive and behavioral criteria as “B,” and criteria related to health conditions and need for skilled services as C and D. The Assessment Tool and its response categories for ADL and cognition mirror those in the MDS Minimum Data Set. The last two criteria under High Needs (E and F) are rather subjective, based on assessor’s opinion about the risks to health and well-being if services are not provided or if they are discontinued. Figure6 shows schematically how Choices for Care is expected to increase the proportion of consumers served in the community.

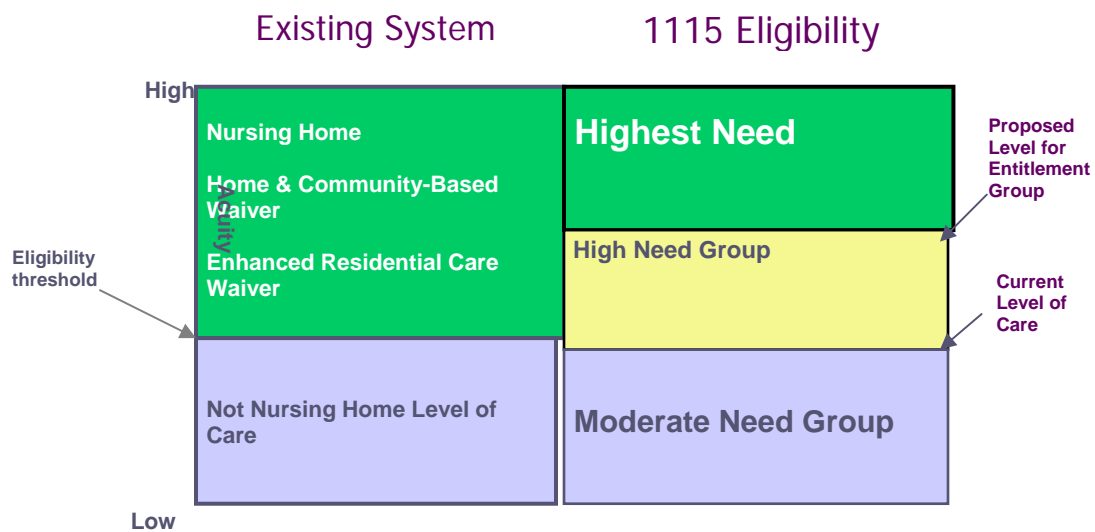


Figure 6 Schematic View of Eligibility for Existing System Versus the 115 Waiver

Table 7. Criteria for Highest, High, and Moderate Needs in the 1115 Waiver

Highest Needs	High Needs	Moderate Needs
A. Extensive or total assistance with at least one of ADL from: toileting; eating; bed mobility; and transfer, <u>and</u> need for at least limited help with any other ADL	A. Require extensive to total assistance on a daily basis with at least one of the following ADLs: bathing; dressing; eating; toileting; and physical assistance to walk; <u>or</u>	A. Needs supervision or any physical assistance 3 or more x a week with any single ADL or IADL, or any combination of ADLs and IADLs;
B. Severe impairment with decision-making skills; <u>or</u> a moderate impairment with decision-making skills and at least 1 behavioral symptoms/conditions, which occurs frequently and is not easily altered, from: wandering; verbally aggressive behavior; resists care; physically aggressive behavior; or inappropriate behavior.	B. Impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following: bathing; dressing; eating; toileting; transferring; and personal hygiene;	B. Individuals with impaired judgment or decision making skills that require general supervision on a daily basis;
C. At least 1 condition that require skilled nursing assessment, monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers; ventilator/respirator; IV medications; naso-gastric tube feeding; end stage disease; parenteral feedings; 2nd or 3 rd degree burns; or suctioning.	C. Require skilled teaching on a daily basis to regain control of, or function with at least one of the following: gait training; speech; range of motion; bowel and/or bladder training;	C. Require at least monthly monitoring for a chronic health condition; or individuals whose health condition shall worsen if services are not provided or if services are discontinued.
D. An unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to at least one of the following: dehydration, internal bleeding; aphasia; transfusions; vomiting; wound care; quadriplegia; aspirations; chemotherapy; oxygen; septicemia pneumonia; cerebral palsy; dialysis; respiratory therapy; multiple sclerosis; open lesions; tracheotomy; radiation therapy; or gastric tube feeding.	D. A condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including (but not limited to) the following: wound care; suctioning; medication injections; end stage disease; parenteral feedings; severe pain management; tube feedings and who require an aggregate of other services (personal care, nursing care, medical treatments and/or therapies) on a daily basis;	
	E. Individuals whose health condition will worsen if services are not provided or if services are discontinued	
	F. Individuals whose health and welfare will be at imminent risk if services are not provided or if services are discontinued.	

Access to the Program

The assessment and approval process has changed under the Choices for Care demonstration program from the system previously described for the waiver for older people and adults with physical disabilities. The existing system decentralized access to 10 regions, whereas entry to the new system will be through registered nurses employed by DAIL. Prior to the program start, DAIL hired and trained 12 registered nurses to conduct assessments for all applicants for nursing home and HCBS who appear eligible for Medicaid. The DAIL registered nurses are co-located with the financial eligibility staff so as to expedite and coordinate the clinical and financial eligibility processes. Hospital discharge planners will no longer be able place Medicaid beneficiaries into a nursing home without an assessment by the DAIL registered nurse unless it is an emergency situation. The DAIL registered nurses will receive the referral, visit the applicant, complete the assessment and screen and determine the priority (highest need, high need or moderate need). Once approved, the participants who choose home and community based services are referred to the case management agency they selected.

Stakeholder Reactions at Outset of Program

In keeping with Vermont traditions, community input was solicited at all stages of development of the plan. We also interviewed stakeholders on their reactions at the outset of the program. Implementation of the “Choices for Care” demonstration was generally supported by all providers although most expressed concerns that the workload might require more than 12 registered nurses and could lead to delays in processing assessments and making level of care decisions.. State officials indicated that the staffing plan was based on nursing home and waiver admission rates, denial rates, and travel time. The workload will be monitored and additional resources will be sought as needed.

Home health agencies and area agencies on aging lose some of their assessment roles in the new project. Some concerns were expressed over that issue, and questions raised about the wisdom of the state-wide assessment model. However, these agencies support making HCBS an entitlement under the demonstration. Case management and provider roles are still envisaged for the local agency network, as note above.

Nursing home providers expect that some facilities will reduce their capacity and others will close in the future due to the expansion of HCBS service, and due Medicaid rates which providers feel are below their costs. This environment may lead some owners to add residential care units, convert nursing home wings to residential care, develop adult day health services or convert shared rooms to private rooms.

One home health agency explicitly was concerned that the Choices for Care demonstration will test its ability to support people with dementia in the community. That agency is considering offering overnight services or awake services available 24 hours a day through its adult day services program to support caregivers who burn out due to the demands during night time hours. Given that agencies have already had some difficulty in recruiting workers, especially for odd hours and on the weekend, some concern has been expressed about caring for an even sicker, more frail group at home. Home health agencies noted their willingness to initiate services for clients whose Medicaid application has not been approved. Staff is familiar with Medicaid financial eligibility rules and comfortable assuming risk while the application is processed. Clients are asked to sign a statement that they will be responsible for payment if they are found ineligible. No figures were available on the frequency of denials.

Although the home health industry in Vermont has ample experience with providing HCBS care under waivers, we note some residual anxiety if the nursing-home supply is allowed to

shrink until it is not readily available as a fall back. Home health agency representatives stated that the system needs a viable nursing home industry. Concerns about the size of existing homes, occupancy rates and reimbursement levels may cause some nursing homes to fail. Informants wondered if another 400-500 reduction in capacity would threaten the viability of the industry. 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.

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 meet the eligibility criteria and wish to remain in or return to the community. As noted earlier, the enabling legislation mandated that DAIL convene a task force to make recommendations for the nursing home of the future in Vermont.

Attendant Care Program

DAIL supports elders and adults with physical disabilities who are capable of directing their own care. The attendant services program began as a state funded program in 1980 for consumers who were able to direct their care. About 250 individuals are served through state general revenues. Consumers apply through the local AAA or home health agency and are reviewed by an eligibility committee that consists of persons with disabilities- two consumers and a representative from DAIL. Committee decisions are reviewed by DAIL adopted unless they are inconsistent with written guidelines. The committee is responsible for determining whether applicant is eligible for attendant services; the extent of need for attendant services; the

number of hours that should be authorized up to 13 hours per day; and the consumer's continuing eligibility and need for attendant services.

The Attendant Services Program Employer Handbook outlines the consumer's responsibilities. Consumers sign an annual agreement and employer agreement form agreeing to be responsible for the following:

- Understand and follow program requirements;
- Recruit and select worker(s);
- Notify selected worker(s) of their responsibilities;
- Assure that employment forms are completed and submitted to the payroll agent;
- Train worker(s) to perform specific tasks as needed;
- Develop a work schedule based on the approved Service Authorization;
- Arrange for substitute or back-up workers as needed;
- Authorize worker(s) timecards (based on the Service Authorization and time worked);
- Maintain copies of all worker(s) time sheets;
- Supervise worker(s) to assure that tasks are performed correctly and completely;
- Evaluate worker(s) performance and provide feedback;
- Terminate worker(s) employment when necessary;
- Notify the payroll agent of any changes;
- Participate in the assessment and reassessment of program eligibility; and
- Communicate with the director or assessor as necessary.

Once certified, consumers 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.

Individuals with developmental disabilities also have a choice of support options. In addition to an agency managed option, individuals may choose to manage some of their supports and receive others through an agency; manage all supports through consumer direction; or receive supports that are managed by a family member.

State officials estimated that consumer direction saved the state more than \$2 million in FY 2000 and a satisfaction survey among program participants found that two-thirds were very

satisfied, and one-third was satisfied. Consumers liked having reliable help (42 percent), control over hiring (31 percent), and knowing the personal care attendant (19 percent). Seventy-one percent of participants found managing their caregivers easy; 19 percent found it very easy; 5 percent found it difficult. 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).²³

Developmental Services Community Programs

Closing the Institution

Vermont closed its only institution for individuals with developmental disabilities in 1993. Opened in 1916, the Brandon School served more than 600 people at its peak in 1968. In 1978, the legislature passed a law that required a review of every resident to determine whether they could move from the institution if support services were available. Though many were able to move, the lack of support services hampered progress. A law suit led to a ten-year plan to develop a service system as the Medicaid HCBS waiver program was implemented. By the end of the 1980s, resources were still limited and the ten year plan had fallen far short of expectations with 180 individuals waiting for services.

A new plan was devised by the Division and in 1992 and 1993, the legislature approved bridge funding to expand community services until savings from relocating residents from the Brandon School could be shifted to community programs. A report on the process attributed its success to the following factors:

- Commitment and support from community providers;

²³ Flood, P. Expanding Long-Term Care Choices for the Elderly. Workshop Brief, September 11-13, 2000, User Liaison Program. Agency for Healthcare Research and Quality, Rockville, MD.
<http://www.ahrq.gov/news/ulp/ltc/ulpltc.htm>.

- Building service provider capacity (staff, training, other resources);
- Integrating relocation with the development of community services;
- Building a crisis intervention support network;
- Collaboration between staff from community agencies and the Brandon School;
- Job search assistance for staff at the Brandon School; and
- Transfer of assets accumulated by the Brandon School (furniture, equipment, vehicles) to community agencies.²⁴

When the institution closed, most family members supported the decision. It was also reported two to three years after the closing that all former residents were doing very well in their new living situations. A follow up survey found wide support from key informants regarding the decision to serve individuals with developmental disabilities in small home like settings.

Organizing the Community Care

About 40% of the individuals with developmental disabilities 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 regulations issued under the state's Developmental Disabilities Act strongly support the principles of self-determination. Care plans are developed through a person-centered planning process and over 500 people with developmental disabilities direct their services, including hiring, training and supervising direct care staff.

²⁴ Shultz, B, Walker, P, Hulgin, K, Bogdan, B, Taylor, S, & Moseley, C (1999). Closing Brandon Training School: A Vermont Story. (a report by Center on Human Policy, Syracuse University and the Vermont Division of Developmental Services, submitted to NIDRR, February, 1999) Waterbury, VT: Mental Health and Mental retardation, Division of Mental Retardation. Available on web at: <http://thechp.syr.edu/Brandon.htm> Visited October 15, 2005.

Geographically based Designated Agencies (DA) are responsible for completing the initial assessment and determining functional eligibility. To qualify, applicants must have a developmental disability diagnosis or mental retardation and have substantial deficits in adaptive functioning. New applications are reviewed by local funding committees composed of DA staff, volunteers, parents, and other agencies develop and recommend a support plan to a statewide equity committee. The committee includes two state agency representatives, providers, and two family members who make final decisions on the support plan and the funding to be authorized. The equity committee was established to create more consistency in support plans and funding across the regions. Prior to the formation of the committee, the support plans were reviewed at the state agency. Officials determined that the criteria for developing support plans was unclear and the reviews tended to support plans based on the way they were written or the organizations that advocated more strongly for their consumers. DDS staffs confirm the functional eligibility and reviews a sample of assessments to ensure they were completed properly.

The care planning process begins with an assessment that is completed by an intake coordinator. The plan of care is completed within 30 days of the assessment and is based on the goals and preferences of the applicant, a comprehensive social history, and a discussion of their life goals rather than service goals. The plan includes support strategies and indicators that are tracked. The DA develops an individualized support agreement with the consumer that includes supplementary information about components of the plan such as a communication plan (what additional services needed for communication support), a support plan, and a list of psychiatric medications that are tracked for side affects that are reviewed by a committee. DDS reviews a random sample of the plan to make sure that the goals are reasonable, are being tracked, and that supports are delivered as planned.

Vermont's system is based as much as possible on one-to-one service delivery, one provider to one client. No one felt that consumers should be served in group settings. Some commentators, however, felt that the system may have gone too far and that some consumers may actually do better in settings that serve two consumers. 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. One Designated Agency representative described a shared living provider model that matches consumers and providers at a base cost of \$19,631 for a year, excluding room and board. Consumers also receive day support services (up to 20 hours a week), case management, and clinical support. A few consumers rent their own apartment and the provider lives with them.

“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.²⁵ 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, needs help finding a job, paying heating bills, has special health care needs, needs help to live independently, has a mental illness, or is deaf or hard of hearing. Based on the information that the consumer enters, 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.

²⁵ Available at <http://screendoor.vermont.gov>.

The home page of the AHS web site carries a list of topic areas (children/families, elderly/disabled, juvenile justice, substance abuse, criminal justice, health issues, mental health) that lead to further information about the programs and services that are available to individuals who qualify. The DAIL home page also lists a range of topics under the heading “how can we help?” The guide has links to advocacy, Alzheimer’s, case management, complaints/reporting abuse, day services for adults, deaf and hearing impaired, employment, financial/income assistance, food/nutrition, fuel assistance, housing/shelter, information and assistance, legal assistance, mental health services, nursing homes/other care settings, prescription drugs, technology/equipment, transportation, blind and visually impaired services and volunteer opportunities. The DAIL home page also has a link to the AHS “screen door.”

Workforce Development

Workforce development has been an ongoing priority in Vermont. In 1999, DAD created a Workforce Task Force to consider improving wages and benefits, improving working conditions and building public awareness of the value of direct service workers. In 2001, Vermont received a Reall Choice Systems Grant that had as a goal to “create a valued, adequately reimbursed, and well-trained workforce” across multiple service systems.” The original Task Force, which became known as the LTC Workforce Council, worked on these objectives with DAD and the Division of Developmental Services. In 2003, they convened a forum to explore best practices in Vermont, which was attended by over 140 policymakers, provider agencies, workers and advocates.

Under the grant, the Workforce addressed the direct care staffing shortages and developed an action plan to create a stable, valued and adequately reimbursed work force that provides

quality care to individuals and families. The task force commissioned a survey and recommendation that included formation of a non-profit organization for paraprofessionals.²⁶ Accordingly, 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.

In 2004, Vermont received a Better Jobs, Better Care award from the Robert Wood Johnson Foundation. 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.²⁷

A Gold Star Employer Program has been established as a major initiative in the Workforce effort. Starting in 2005, Gold Stars will be awarded to nursing homes that achieve best practices in recruitment and retention during the previous year. To win this award, the nursing homes must conduct a self-assessment on their practices and then develop goals for at least 2 from a list that includes: staff recruitment, orientation and training; staffing levels and work hours; professional development and advancement; team approaches; and staff recognition and support. Vermont is also creating five annual Quality Awards with a monetary prize of \$25, 000. Only Gold Star facilities will be eligible for awards.

²⁶ <http://www.vermontelders.org/VT%20Association%20of%20Professional%20Care%20Providers.htm>

²⁷ <http://www.vermontelders.org/Better%20Jobs%20Better%20Care.htm>

Section IV. Quantitative Markers of Rebalancing

Use of Nursing Homes 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 another 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 HCBS was intended to defray.

Methods

To create the new admission sample we used all MDS admission assessment records in 2002, 2003, and 2004 to calculate the NH Case Mix at admission. The numbers of new admissions in 2002, 2003, and 2004 were 3,733, 3,961, and 3,679 respectively. This included multiple admissions of the same individual in the same or different NH.

For the 3 months after admission sample we used MDS quarterly records in 2002, 2003, and 2004 to calculate NH Case Mix at 3 months after admission. First, we selected all MDS quarterly records into a separate data file. Then we merged this data file with the admission records data files using both a unique resident ID and a unique facilitate ID. Then, we calculated the day-difference between the admission date and the assessment date of the quarterly data file. The first quarter assessments were identified if the day-difference was between 75 days and 105 days. Finally, we used these first quarter assessment records in our case mix analysis.

We calculated the ADL score following the method developed by Morris and colleagues for the MDS ADL Long-Form.²⁸ Specifically, we used variables G1AA (bed mobility), G1BA (transfer); G1EA (locomotion on unit), G1GA (dressing), G1HA (eating); G1IA (toilet use), and G1JA (personal hygiene). The original coding for these variables were between 0 and 4 (0 for independent, 1 for supervision, 2 for limited assistance, 3 for extensive assistance, and 4 for total dependence) and a number 8 was used when the activity did not occur during the entire 7 days of assessment. We recoded the number 8 (activity did not occur during the entire 7 days) as 4 (total dependence). We finally created a summation score of total ADL dependence by adding the value of these 7 variables. Therefore, the possible score of our ADL variable is between 0 and 28. A higher score means higher ADL dependence.

We used the Cognitive Performance Scale (CPS) developed by Morris and colleagues to measure the cognitive functioning of elders in NH.²⁹ The CPS was calculated using variables from section B (B1: Comatose; B2A: Short term memory), section C (C4: making self understood), and section G (GHA: eating) of the MDS. The possible score of CPS is between 0 and 6. A higher CPS score means lower cognitive functioning.

Results

Table 8 shows the changes in the NH case mix on admission. Between 2002 and 2004, the functioning level of elders admitted to NHs in VT deteriorated slightly from the average ADL score of 14.29 in 2002 to an average ADL score of 14.63 in 2004. During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average

²⁸ Morris, J. N., B. E. Fries, et al. (1994). "MDS cognitive performance scale." Journal of Gerontology: Medical Sciences **49**(4): M174-M182.

²⁹ Morris, J. N., B. E. Fries, et al. (1999). "Scaling ADLs within the MDS." Journals of Gerontology. Series A, Biological Sciences & Medical Sciences. **54A** (11): M546-M553.

CPS score went down from 1.92 in 2002 to 1.77 in 2004. Moreover, the rate of persons with no cognitive impairment or mild impairment increased.

Table 8: Change in NH Case Mix Based on Admission Values - Vermont

	2002	2003	2004
ADL score	%	%	%
0	3.4	3.6	3.9
1	1.2	1.3	0.8
2	2.0	2.0	2.0
3	1.7	1.8	1.2
4	2.5	1.9	2.0
5	2.3	2.3	2.1
6	2.4	2.8	2.6
7	2.5	2.4	2.0
8	3.0	2.7	2.6
9	3.0	2.6	2.0
10	4.9	4.2	4.2
11	4.2	3.5	3.3
12	5.2	6.2	5.9
13	5.3	5.2	5.0
14	5.2	5.7	4.8
15	4.8	4.8	5.6
16	5.0	5.2	5.5
17	5.0	4.9	5.6
18	6.7	6.9	8.7
19	8.1	7.8	8.0
20	4.2	4.4	5.0
21	3.5	3.7	3.5
22	3.2	2.8	3.3
23	1.7	2.3	2.2
24	2.2	1.7	2.0
25	1.5	1.4	1.3
26	1.2	1.4	0.9
27	1.4	1.8	1.1
28	2.8	2.8	2.8
Mean ADL	14.29	14.38	14.63
N*	3,733	3,961	3,679
CPS score			
0	25.3	27.5	29.7
1	16.5	17.5	17.1
2	19.1	18.9	18.3
3	27.2	23.5	23.7
4	6.1	7.3	6.0
5	3.5	3.4	3.0
6	2.4	2.1	2.2
Mean CPS	1.92	1.84	1.77
N*	3,733	3,960	3,677

Table 9 shows the NH case mix 3 months after admission for 2002, 2003, and 2004. Here we do not see a clear pattern in the direction of the change in ADL over the 3 years period. The ADL functioning at 3 months after admission improved slightly between 2002 and 2003 and then deteriorated slight 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 suggests 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 to develop resources to serve people with Alzheimer's disease in the community.

Table 9: Change in Case Mix in Vermont Based on Values at 3 Months Post Admission

	2002	2003	2004
ADL score	%		
0	5.2	6.5	6.1
1	1.1	1.7	1.7
2	2.6	2.4	2.5
3	2.3	2.4	3.4
4	3.6	3.2	3.6
5	3.6	2.6	2.5
6	3.6	3.7	3.0
7	2.9	3.1	2.4
8	4.1	2.9	2.8
9	4.1	4.8	2.8
10	3.5	4.3	3.8
11	4.4	3.9	3.8
12	3.5	4.8	4.6
13	4.7	4.9	3.7
14	4.7	5.3	3.8
15	5.3	4.0	5.6
16	5.0	5.0	4.3
17	5.3	4.9	5.6
18	5.2	5.3	6.6
19	5.0	5.3	5.5
20	3.0	4.0	3.6
21	4.1	3.2	3.8
22	3.9	1.3	3.2
23	1.4	2.2	1.8
24	1.8	2.4	1.9
25	2.1	1.3	1.7
26	1.1	1.3	1.0
27	1.8	1.7	1.7
28	1.2	1.8	3.2
Mean ADL	13.18	12.93	13.48
N	660	875	835
CPS score			
0	14.4	14.2	14.5
1	11.4	10.9	12.7
2	19.9	18.1	17.7
3	35.6	35.9	35.2
4	10.0	10.9	10.7
5	7.1	7.5	7.1
6	1.7	2.6	2.2
Mean CPS	2.43	2.52	2.45
N	660	875	835

Relationships between Community Care and Nursing Home Care

Figure 7 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.

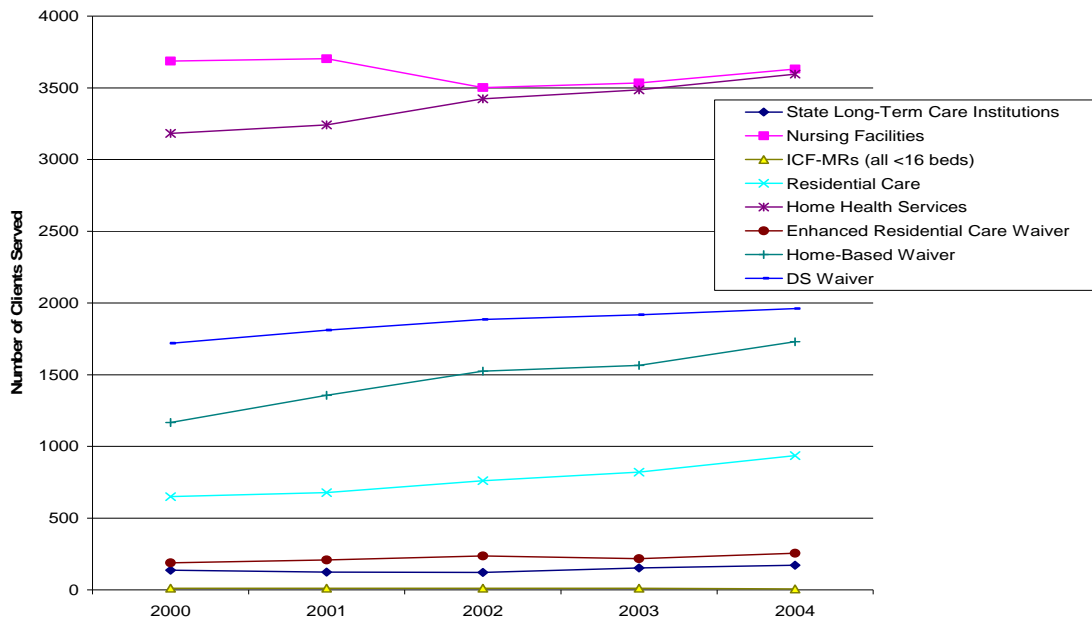


Figure 7. Clients Served in Selected Vermont Programs, 2000-2004

Figure 8 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 9 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.

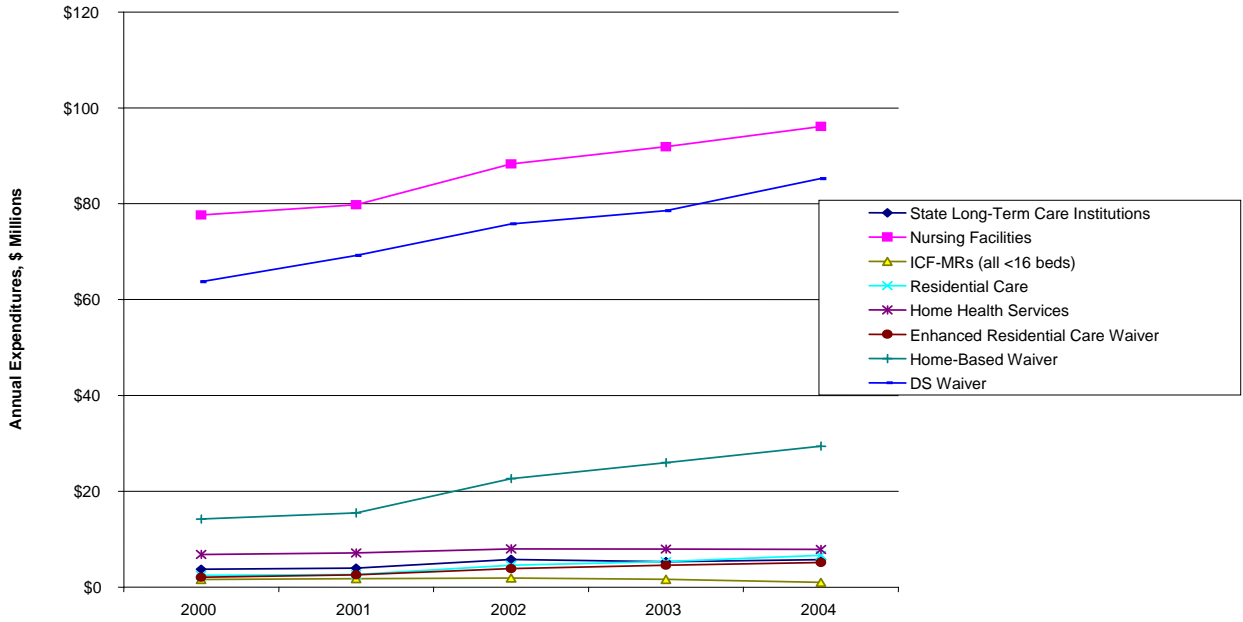


Figure 8. Expenditures for Selected Vermont Programs, 2000-2004

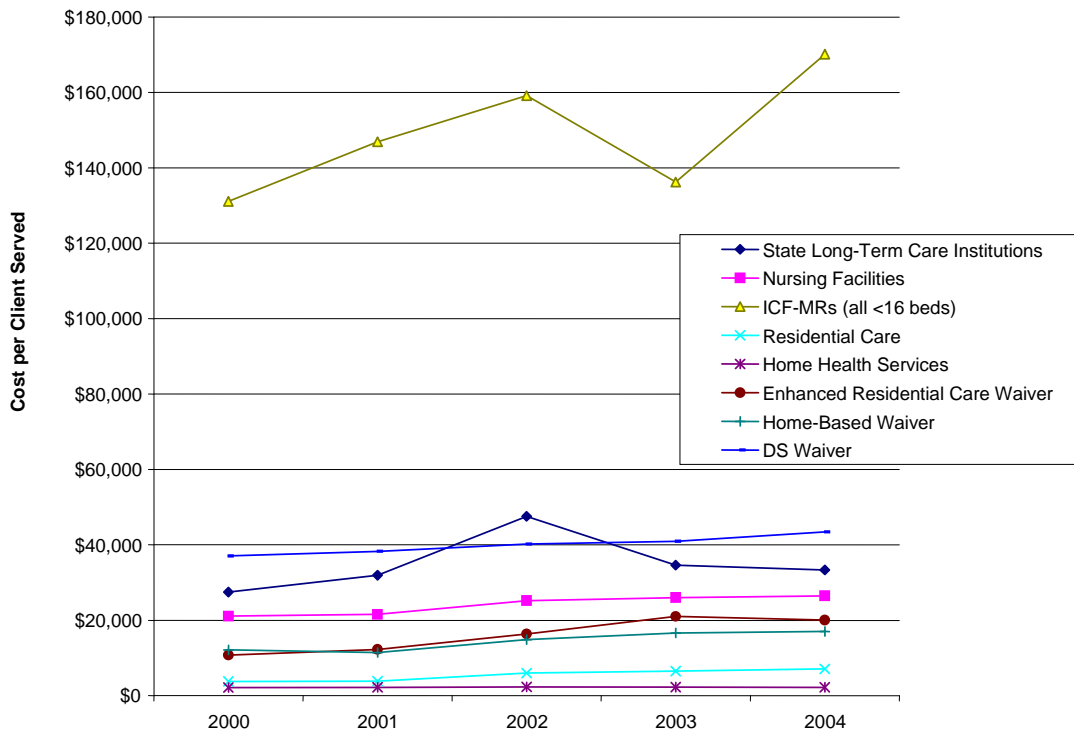


Figure 9. Costs Per Participant in Selected Vermont Programs, 2000-2004.

Concluding Comments

General Conclusions

The Vermont long term care system is led by people with a clear and consistent vision of what needs to be done to provide those who need supports with an array of services and options to meet individual needs in the community. Those in charge of the system have held leadership positions long enough to gain the support of decision makers, providers and consumers in the long term care system. They are seen as credible leaders who are committed to continuous improvement in the state's long term care system. The state leaders have also had the time and understanding of the system to be strategic and thoughtful in ways to improve the system to better meet the needs of those in need of long term care services. Because most component parts of the long term care system are located in one place in the state administrative structure is an asset, more efficient and effective planning can be undertaken to develop and deliver 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 and goals for balancing its long term care system and designed an array of strategies to achieve the benchmarks. Concerns about access and fragmentation in the early 1990s led to a concentration on focusing 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

Many of the building blocks and initiatives discussed here are new or even under development. In the next two years, the case study updates will explore the following.

- Early implementation of the 115 waiver, and the extent to which it can further change the balance of service, especially for old people.
- The recommendations about the future 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.
- The reactions and adjustments among local community providers to the new system of access for seniors and persons with disabilities.
- The implementation of the PACE projects and other managed care initiatives.
- The ongoing transformation of mental health services in Vermont and the closing of Vermont State hospital.
- The continued administrative evolution of DAIL.
- The housing initiatives under way.
- The further development of an innovative assistive technology program.
- The effects of the Workforce policies, including the Gold Stars and monetary quality awards.

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. It then remains to be discussed how the lessons from Vermont might be adapted to a much more populous state.