REIMBURSEMENT PRACTICES AND ISSUES IN VERMONT'S LONG-TERM CARE PROGRAMS

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FOREWORD

"Would you tell me, please, which way I ought to go from here?"
"That depends a good deal on where you want to get to," said the Cat.
Alice's Adventures in Wonderland

It might be helpful to explain the genesis and process of this report before tackling the larger question posed above. As part of the Vermont Department of Disabilities, Aging and Independent Living (DAIL) Workforce Council's work plan in 2005, The Community of Vermont Elders (COVE) agreed to convene a Reimbursement Forum with the Vermont Healthcare Association, the Vermont Assembly of Home Health Agencies, and the Vermont Association of Adult Day Services and Assisted Living. At the same time COVE was and is currently sponsoring three workforce projects all aimed at improving the quality of care and the quality of jobs: Better Jobs Better Care (BJBC), The Vermont Association of Professional Care Providers (VAPCP) and Northern New England Leadership, Education and Advocacy for Direct Care and Support (LEADS).

Each of these projects includes a public policy component. While COVE already has an existing policy committee, its legislative agenda is significant and broad, thereby preventing workforce issues from receiving sufficient time and focus. Consequently, COVE established a Long-Term Care (LTC) Workforce Policy Committee with representation from multiple long-term care settings, COVE's three workforce projects and other appropriate stakeholders. This collaborative approach allowed us to give attention to the emerging workforce policy issues and strategize about collective approaches rather than working in isolation.

Reimbursement emerged as one of the priorities of the LTC Workforce Policy Committee. Initial dialog at the first Reimbursement Forum served as a foundation for further discussions with the committee. Several participants reported that the Reimbursement Forum was the first time that providers from multiple long-term care settings met to address these important issues collectively. Discussions began with the recognition that direct-care workers in all settings deserve respect, training, reliable hours and adequate compensation and benefits.

Improving conditions for and elevating the status of direct-care workers are core goals of COVE's three workforce projects. These projects have included individual work with sites, curriculum development, training, best practice initiatives and other activities alongside the policy work. We clearly recognize that the issue of adequate compensation and benefits is directly linked to the financial well-being of provider/employer organizations. We also recognize the relationship of reimbursement and financial stability/integrity to quality care.

This study paper represents a first attempt to clarify and explain an extremely complex and confusing reimbursement system. It is our hope that it will serve Vermonters as we try to understand and plan a better long-term care system. We trust it will inform the work of several legislative studies currently underway: the Long-Term Care System Sustainability Study, Direct Care Workforce Study, Nursing Facilities for the 21st Century as well as the Nursing Facility Reimbursement Study. The COVE reimbursement study represents only a modest beginning, but an important one. While the study aimed to be comprehensive in scope, we have not included data for Developmental Services since a separate study is underway. It is our intention that this document will be used for further analysis, advocacy and action that will truly strengthen Vermont's LTC system.

During the Reimbursement Forum and subsequent committee meetings, the group strived to understand the reimbursement system as a whole. The differences, complexities and nuances across settings quickly surfaced. It is tempting but dangerous, however, to consider only ad hoc remedies that focus on one element of the continuum, rather than the long-term care system as a whole. Each setting/service plays an essential and critical role. Despite distinct reimbursement structures, settings and services, they are interrelated and changes in one area impact other aspects of the system. In addition Vermont is intentionally moving toward more community based options as evidenced by the Choices for Care Waiver Program. It is essential that, in this process of rebalancing and choice, we ensure that Vermonters' true needs are met. We all recognize that resources are limited and as a state we need to be strategic about allocating resources efficiently, effectively and humanely.

We would like to express our thanks to the Paraprofessional Healthcare Institute (PHI) and specifically Dorie Seavey and Hollis Turnham for their excellent technical assistance in researching and drafting this document. Funding from Better Jobs Better Care made it possible for us to secure their valuable expertise. We would also like to thank the following key contributors: Mary Shriver of VHCA, Peter Cobb of VAHHA, Peter Coutu and Lynn Bedell of VAADS, Nancy Eldridge from Cathedral Square Corporation representing Assisted Living and Joan Senecal and Mike Meunier from DAIL. Finally, we would like to acknowledge Erica Garfin for her work finalizing the draft.

Each stakeholder of Vermont's long-term care system adds to the vision of what we can accomplish together. COVE's vision is that:

- Caregivers are valued, supported and compensated in keeping with their vital role in maintaining the dignity, security and well being of Vermonters;
- Resources, education, information and services, key to successful aging, are broadly available and allow for individually appropriate choices;
- Quality health care is accessible to all residents; and
- Public policy is informed by and responsive to the aspirations and challenges of the state's growing elder population.

This paper will help us engage with the important details as we work to understand what is and what really needs to be in place for a shared vision.

Dolly Fleming, Executive Director of COVE

I. INTRODUCTION

Dramatic changes have taken place in Vermont's long-term care industry over the last two decades. Vermonters relying upon nursing facilities today received their care in hospitals ten years ago. Residential care homes currently deliver services that were at the core of nursing facility care twenty years ago. Furthermore, most consumers want to have long-term care services and supports delivered to them in their own homes and apartments. While these transformations in services have occurred in most states, Vermont continues to position itself at the forefront of state long-term care reform efforts, beginning with the passage of Act 160 in 1996, and most recently with the receipt of a first-of-a-kind federal 1115 Medicaid demonstration waiver called Choices for Care.

Act 160 required Vermont to take saved dollars from reduced Medicaid nursing home utilization and shift those funds to home-based care, beginning a steady expansion of Vermont's home- and community-based services to serve an increasing number of elderly individuals and individuals with physical disabilities in non-nursing home settings. In support of these "rebalancing" goals, the new Choices for Care waiver allows Vermont to pool funds for nursing home and home- and community-based care, in principal eliminating the federal Medicaid program's bias toward nursing home care, and thus allowing elders, persons with disabilities, and their families to choose where an individual will receive care based on their assessed needs.

The success of Vermont's new Choices for Care approach depends on three critical factors:

- The capacity to direct the state's finite long-term care resources to the "Highest and High Need" long-term care consumers who meet nursing facility level of care, so that savings can be generated to pay for the services for additional people including those with moderate needs who do not meet nursing facility level of care.
- The ability of clients in one setting, or with one bundle of services, to transfer seamlessly to other settings, or to receive different services based on changes in their level of need, thus generating system-wide efficiencies while giving consumers choice as to the setting in which they receive their services.
- The existence of alternative residential settings affordable to the Medicaid population and the availability of housing units within those settings reserved for Medicaid beneficiaries.

Ultimately, these factors are tied to the financial health and capacity of Vermont's provider infrastructure throughout the long-term care system. Since public payers (chiefly Medicaid and Medicare) are responsible for about two-thirds of the long-term care purchased, that health and capacity are closely tied to the reimbursement or payment rates set by the public sector.

II. PURPOSE

This report has two main purposes:

- To survey the current public reimbursement methods employed in each of Vermont's long-term care settings and/or programs.[1]

- To lay a foundation for future analysis of the strengths and weaknesses of these various payment methods in terms of their impact on system sustainability, the quality of care received by consumers, and the quality of direct-care jobs.

This report focuses primarily on publicly funded long-term care services for older adults and persons with physical disabilities, since the Vermont Legislature recently ordered a separate study of the sustainability of services for people with developmental disabilities and mental health issues.

III. BACKGROUND

Vermont's publicly funded long-term care system encompasses two main types of care:

- Skilled nursing services and related care
- Non-medical personal care and supportive services

These services and supports are provided in five different types of settings by six different types of providers (see Exhibit 1). Skilled nursing care, for example, while traditionally provided in nursing facilities, is also provided in people's homes, in adult day centers and in congregate and supported living residences. The complexity of these overlapping services, settings, and providers stems from the fact that people with similar diagnoses, conditions, and needs can and are well served in a variety of settings, and with an array of possible services depending largely on service availability, consumer choice, and the existence of informal supports.

Exhibit 1: Long-Term Care in Vermont:
Types of Services & Supports, Settings, and Providers

Types of publicly reimbursed services and supports	Settings in which services are offered	Types of providers *
Skilled nursing care	Nursing facilities Private residences Congregate living Supported living Adult day centers	Nursing facilities Home health agencies Assisted living facilities & residential care homes Adult day providers
Non-medical health care, personal care and supportive services	Private residences Residential care homes Assisted living residences Adult day centers	Home health agencies Consumer- & surrogate-directed care providers For-profit agencies providing non-medical care Assisted living facilities & residential care homes Adult day providers

*Vermont's five Area Agencies on Aging also provide case management and arrange for care plan services for seniors and also for younger adults with disabilities who participate in the Choices for Care Waiver.

Vermont currently has **three Medicaid waivers that provide skilled nursing care, non-medical home care, and personal care and supportive services to adults:** Choices for Care, Developmental Services, and Traumatic Brain Injury (TBI). Together, these three waivers serve approximately 5,984 people:

- Choices for Care serves 3,895 participants (2,150 in nursing facilities and 1,745 in home- and community-based care).
- Developmental Services Waiver serves 2,040 participants.
- TBI serves 49 participants.

The Choices for Care and TBI waivers provide services to elders and people with physical disabilities who qualify for nursing facility level of care. Recipients must also meet the financial criteria for long-term care Medicaid. The Choices for Care waiver also has functional and financial criteria for admission to the "Moderate Need Group."[2] This group qualifies for preventive services but does not need nursing facility level of care nor do participants need to be financially eligible for LTC Medicaid.

In addition to Medicaid Waivers, there are **four other programs in Vermont which provide personal care and supportive services** to the elderly and to adults and children with disabilities **and one program which provides skilled nursing care** and case management services to individuals who are living at home and dependent on life-supporting medical technology:

- Attendant Services Program (ASP)
    - Participant-directed
    - Medicaid State Plan service
- Assistive Community Care Services (ACCS)
- Children's Personal Care Services Program (CPCS)
- Day Health Rehabilitation Service Program (DHRS) (also provides skilled nursing care)
- Hi-Tech Services Program

The Hi-Tech Services Program is funded under Vermont's state Medicaid plan as are ACCS, CPCS, and DHRS. The Attendant Service Program is funded with both General Fund dollars and the Medicaid State Plan.

An important development in Vermont's long-term care landscape is the increase in consumer-directed personal care and supportive services. Vermont, like many states, supports long-term care consumers living in their own residences who want to hire their own attendant care workers rather than using agency services. In fact, over half of the home-based participants in Vermont's Choices for Care Waiver receive their services from paid "independent" caregivers who are hired, trained and supervised by the participant or his/her surrogate. Often these consumer-directed caregivers are family members or friends. In addition, as part of its new Choices for Care waiver, Vermont recently became one of twelve states to join the second wave of Cash and Counseling demonstrations in the United States. In this program, referred to as "Flexible Choices" in Vermont, participants cash out 85 percent of the value of their services, create a flexible monthly individualized budget, and arrange for their own services and supports with the assistance of their consultant.

IV. Reimbursement Rate-Setting Methods and Issues in Vermont's Long-Term Care Programs

A. Nursing Facility Services

Federal Medicaid statutes require that states make available 24-hour skilled nursing and custodial care to eligible individuals who cannot care for themselves either because of physical, emotional, or mental problems, because they can no longer care for their own personal needs (such as eating, bathing, using the toilet, moving around, or taking medications), because they have extensive medical needs requiring round-the-clock nursing care, or because a physician has recommended nursing facility residency.

Nursing facilities offer an array of services, ranging from skilled nursing care (such as rehabilitation or care performed by licensed nurses) to non-skilled, or personal or custodial care. Nursing homes provide a room to live in, all meals, activities, personal care, rehabilitation services, and 24-hour licensed nurse supervision and access to medical services.

As of January 2006, there were 43 nursing homes in Vermont providing 3,457 licensed beds to seniors and people with physical disabilities who require nursing care. Three of the facilities accept private-pay individuals only, although one of those is also Medicare-certified. The remaining 40 homes are all dually certified to accept Medicare and Medicaid residents. Fifteen of Vermont's nursing homes are non-profits and six of these are classified as "hospital-based" or "hospital-related"[3]. One nursing facility, the Vermont Veterans Home, is managed by the state and is subject to federal Veterans Administration requirements and funding.

In Vermont, over two-thirds of nursing facility residents have their care partially or completely supported by Medicaid. Medicare pays for another 10 percent, and another 16 percent pay totally for themselves relying on insurance, personal and/or family assets, or Veterans and fraternal organization benefits. About 10 percent of the state's nursing-facility capacity is unused.

Since the passage of Act 160 in 1996, state Medicaid nursing home expenditures have continued to grow, increasing from $77.8 million in FY 1999 to $101.4 million in FY 2004, and to $102.5 million in FY 05. Part of the expenditure growth is due to annual inflationary adjustments to nursing home reimbursement rates. At the same time, over the last decade (1996 to 2005), nearly $50 million in projected nursing home expenditures has been transferred to support in-home care and community-based services.[4]

The total number of nursing home beds in the state declined 10 percent from FY 1996 to March 2006 (from 3,848 to 3,457). This contraction is in sharp contrast to the early 1990s when Vermont's nursing facility industry was adding beds. While occupancy rates and the number of licensed beds have declined over the past decade, the average acuity level of residents has increased slightly, as more people choose home- and community-based care and remain at home longer or never enter a nursing facility at all. As a result, many nursing facilities in Vermont now offer extensive rehabilitation services for Medicare residents; these services are reimbursed at

much higher reimbursement rates than Medicaid. (See Appendix 1 for recent Medicaid-funded participant data.)

Reimbursement Method under Medicaid

Vermont's Medicaid nursing facility reimbursement system was last revamped in 1998 in order to better align it with the goals set forth in Act 160 and because key elements of the methodology were outdated.[5] The significant changes made at that time were to:

1. Update the system used to classify residents' needs by substituting the nationally developed Resource Utilization Groups (RUG) for the modified version that Vermont had been using.
2. Shift to calculating payments to facilities based only on the acuity level of their Medicaid residents rather than on the case mix of their entire census.
3. Eliminate the return on equity allowance.

Today, reimbursement rates for Vermont's privately-owned Medicaid nursing facilities[6] are set prospectively by the Division of Rate Setting within the Vermont Agency of Human Services. The rates are based on the historic allowable costs of providing service in a base year, and according to an acuity-based payment structure that pays higher rates for residents with higher care needs based on a case-mix weight classification (44 classifications).[7] Allowable costs are grouped into six cost categories: nursing care, resident care, indirect costs, director of nursing, property and related costs, and ancillaries. Some cost categories are subject to limits. For example, nursing costs are reimbursed at the nursing facility median plus 15 percent, resident care is reimbursed at the median plus 5 percent, and indirect costs are reimbursed at the median.[8] For the director of nursing, 100 percent of costs are reimbursed. It should be noted that the state-owned Vermont Veterans Home is not subject to median limits. Furthermore, three hospital-based nursing homes are reimbursed at the median plus 35percent for nursing care costs, resident care at the median plus 20 percent, and indirect costs at 137 percent of median.

Rates also are affected by the state's **minimum occupancy requirement**. This requirement means that facilities operating at less than the minimum occupancy rate are financially penalized, since per diem costs for each cost category, excluding the ancillary cost category, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered or the number of resident days that would have occurred if the facility had been operating at the required minimum occupancy. (Note: As of July 1, 2006 nursing care costs will be excluded from meeting the minimum occupancy requirement.) Homes that operate at or above the minimum occupancy requirement are also penalized due to the fact that this requirement causes the median in all cost categories to drop. The current minimum occupancy level is set at 93 percent; however, the Vermont Legislature reduced it to 90 percent for FY 2007 only.

Nursing care costs are **rebased** no less frequently than once every three years and other costs are rebased at least every four years, unless the Secretary of the Agency of Human Services, on the advice of the Director of the Division of Rate Setting, certifies to the General Assembly that the rebasing is unnecessary or if a modification of these provisions is authorized by statute.[9] Rates effective at the beginning of 2005 were based using actual costs or expenditures incurred in 2002. Before January 2006, rates were based on costs reported in 1997. Rates are **updated** every year with an inflationary factor which compensates somewhat for the infrequency of rate

increases. Property and related costs, as well as ancillary costs, are updated when the nursing facility's cost report is settled. As of January 2006, Medicaid per diem rates in Vermont nursing facilities ranged from $99.03 to $230.00 (the rates for seven facilities reflect special circumstances), with an average per diem rate of $152.42. Facility case mix scores ranged from 0.9937 to 1.1417.[10]

Vermont's nursing facility **provider tax** plays an important role in the financing of the state's public long-term care system. In the early 1990s, Vermont and Rhode Island were the first states in the country to impose such a provider tax. In Vermont, the tax has increased from $50/bed per year to $3,788 per bed per year. The tax is paid by facilities on every licensed nursing home bed and is matched at 58.49 percent with federal dollars. A proportion of the tax is returned to the facilities for Medicaid patient days provided. The extra revenue raised from the tax goes to the administration of the state's Medicaid program, Act 160, and the state's General Fund. For 2005, nursing homes paid $13,162,270 in provider tax of which $9,050,390 was received back in their Medicaid rates; $4,111,881 went to the state and/or other programs.[11]

In response to a provider suit alleging that the cost of care was not being met, and therefore that the ability to provide quality care was at risk, Vermont instituted a **wage supplement program in 1999**. The state increased the nursing home bed tax by $534.25 per year and directed the accompanying increased federal and state revenue to staffing in the form of a monthly facility-specific wage supplement based on the amount of each facility's total staff wages and benefits (excluding the facilities administrator's wages and benefits) in the last quarter of calendar year 1998. The settlement agreement states: "The Defendants agree that the net revenues of the $534.25 increase in the nursing home assessment will be used along with the federal matching funds to provide a pool of funds to be used for an annual wage supplement for all Vermont nursing homes participating in the Medicaid program." A yearly report was required showing the amount of wage supplement payments and increases in facility salaries and wages, and, at the end of the wage supplement term, facilities were required to pay back any excess of supplements over actual staff-related expenses. According to the Division of Rate Setting, from FY00 through FY03 nursing homes received $24 million in accumulated wage supplement income. In this same period, the nursing homes spent $73.9 million on wages and benefits for the eligible staff. In the nursing category, overall hourly wages increased approximately 36 percent, with a roughly 30 percent increase in all of the reported employee categories. Health insurance premiums rose by about 15 percent.[12] Under the terms of the lawsuit settlement, this enhancement program expired on December 31, 2004.

Beginning in 2004, the Vermont Health Care Association (VHCA), in cooperation with the Vermont Department of Disabilities, Aging and Independent Living (DAIL) launched a culture-change initiative to improve staff retention in nursing facilities called the "**Gold Star Employer Program**." This program highlights "best practices" in seven practice areas and awards qualifying nursing facilities a *Gold Star Employer* designation when they demonstrate that they have met their best practice goals.[13] To achieve Gold Star Employer status, nursing facilities must conduct a self-assessment of their use of best practices and develop goals for a different practice each year. While the program does not create rate enhancement incentives, DAIL and VHCA recognize the facilities designated as Gold Star Employers, and facilities can use the Gold Star logo in their advertising. [14]

Provider Cost Structure and Industry Financial Trends

The financial health of Vermont's nursing home industry has been deteriorating. Five facilities have closed since FY 2002, and the number of certified beds has declined by 387 or 10 percent from FY 1996 to March 2006. The State has provided special rates in certain circumstances in order to stabilize the finances of particular providers. VHCA reports that several facilities are currently on the brink of closure.

In 2004, the average Medicaid rate was $147.09 per day while the average cost per day to provide care was $169.92[15]. This underpayment of $22.83 per day in allowable costs results from the state's Medicaid reimbursement methodology. In FY 2006, the average Medicaid reimbursement for a day of care was $156.40. VHCA estimates that actual average costs are in fact 43 percent higher, or approximately $200/day. (The Division of Rate setting has not settled all the 2005 cost reports yet.)

Nursing facilities attempt to make ends meet by cost shifting—that is, using payments received for private-pay and Medicare recipients to subsidize the Medicaid rate. Facilities have to pay attention to their resident mix and may choose to admit a private-pay or Medicare resident over a Medicaid resident in order to manage their revenue and cash flow.

According to DAIL, "[t]he Department is collaborating with the Vermont Health Care Association to develop a strategic plan which will determine the most efficient supply of nursing home beds in any given area and work to preserve that number."[16] The Department's current goal is to achieve a ratio of 60 nursing home residents for every 40 home and community-based waiver participants in each county. The goal is to eventually reach a 50 – 50 ratio. The Legislature has directed DAIL to complete two studies by January 15, 2007: one on the sustainability of the long-term care system and another on the nursing facility reimbursement system. The reimbursement study received a state appropriation of $25,000, matched with another $25,000 from the Vermont Health Care Association, underscoring the importance of this analysis for all stakeholders.

In 2005, the nursing home sector was affected by several changes that increased financial pressure on all providers:

- **The minimum occupancy requirement was raised**. For many years, Vermont based its Medicaid nursing facility reimbursement on a minimum occupancy level of 90 percent, excluding the cost of nursing care. In July 2005, the state increased this minimum level to 93 percent (the Governor recommended 95 percent). Current average occupancy for nursing facilities in Vermont is actually slightly less—91.5 percent as of February 2006, down from 97 percent ten years ago. In fact, 16 out of the 40 Vermont's nursing homes accepting Medicaid payments were operating below 93 percent occupancy in February 2006.[17]
- The Vermont Legislature **increased the Bed Tax** for FY 2006 by $111.73, raising it to $3,787.79 per bed.
- **The FY 06 Medicaid appropriations for the nursing facility sector were reduced.** Savings totaled $1.5 million (the Governor proposed a $10 million cut) from an overall Medicaid budget of $976,149,883.[18] The savings were to be offset by the change in the

minimum occupancy rate. The cuts resulted in a loss of $11.2 million in Medicaid funding throughout the nursing facility sector in 2005.

Reimbursement Challenges

1. **Vermont's nursing facility sector is currently operating under difficult pressures.** On the one hand, the industry is gradually downsizing due to changes in the market, i.e., more people are choosing home- and community-based care options and more older Vermonters are staying healthier until later in life. In FY06, the state required nursing facilities with Medicaid residents to operate at 93 percent capacity or be financially penalized, since paying for unoccupied beds is not good fiscal policy. On the other hand, the state wants to preserve access to the appropriate number of nursing home beds throughout the state. Legislation passed in 2006 returned the minimum occupancy requirement to 90 percent and once again excluded nursing care costs from the rate setting methodology. However, these reimbursement changes are for one year only.
2. **When nursing facilities do downsize by taking beds offline, their reimbursement rate decreases** because of the way the rate is structured, i.e., the decreased number of beds is divided into essentially the same costs, resulting in a lower median, and therefore a lower reimbursement rate. Thus, downsizing typically undermines a facility's bottom line, increasing financial pressure. Occasionally the Division of Rate Setting will make a rate adjustment in return for decreased bed capacity in a particular facility. The Division is also able to grant "extraordinary relief" in some cases when a nursing facility is facing immediate danger of failure. This relief is meant to protect Medicaid residents, and may take the form of a special rate adjustment, an advance on Medicaid payments, or other relief deemed appropriate. A number of facilities have been applying for, and in some cases receiving, extraordinary relief. VHCA believes that this piece-meal method of helping facilities is not constructive for the industry as a whole, and that a reformed method of Medicaid reimbursement would be preferable. The state has recently offered rate incentives for nursing homes to take beds off line.[19]
3. **Because Medicaid rates do not cover the actual costs of providing care, nursing facilities may have an incentive to admit residents based on their financial status and the type of third-party payer, if they have one.** For Medicaid-dependent consumers, this means that they may have difficulty accessing a facility near their family and community. Since the state as a whole has over 300 empty beds at any given time, access ultimately is usually not a current problem.
4. **Vermont's reimbursement methodology for Medicaid nursing facility care currently contains no rate enhancements to create incentives for positive performance related to achieving workforce outcomes that support quality care through quality jobs.**

B. Home Health Care Services

Home health care agencies provide a wide array of long-term care services and supports to consumers outside of licensed residential settings. These services include, but are not limited to, skilled nursing care, intravenous therapy, respiratory/inhalation therapy, electrocardiology, physical therapy, occupational and recreational therapy, and hospice services. Home health care can also include speech-language therapy, medical social services and personal attendant care (the latter service is treated separately in the following section on Personal Care and Supportive Services). Home health care services are provided under an array of programs, including the state's Medicaid plan (the general plan, Children's Personal Care Services and the Hi-Tech Services Program[20]) and under two Medicaid waivers (Choice for Care and Traumatic Brain Injury).[21]

The structure of Vermont's Medicaid home health care delivery system is somewhat unique among states due to the existence of a certificate of need (CON) requirement for home health agencies. Such a requirement is found in only about 15 states. The purpose of the CON process is to ensure access to services, maintain quality of care, and contain costs. Currently eleven non-profit, Medicare-certified home care agencies in Vermont and one for-profit agency have received CON approval to provide Medicaid services. Each non-profit agency serves a single, designated geographic area. The for-profit agency covers the entire state.

For the average non-profit home care agency in Vermont, Medicare accounts for about half of its revenues and Medicaid for roughly another 30 percent. The remainder comes from donations, private insurance, town funds, and private-pay consumers.

The non-profit network serves about 22,000 people annually. Just over 80 percent of its revenues are from Medicaid and Medicare. In 2004, the non-profit agencies made 88,178 home visits to 23,339 Vermonters. Total revenues were $88.6 million, with just over half (51.1 percent) derived from Medicare and almost a third (31.5 percent) from Medicaid.

Reimbursement methods

Under Vermont's **Medicaid** program, general home care services are reimbursed on a per-visit basis according to payment rates set by the Office of Vermont Health Access within the Agency of Human Services. Unlike nursing facility payments, rates do not vary according to the acuity of the client but do vary according to the specific type of service provided (e.g., nursing, physical therapy, personal care). The Department of Disabilities, Aging and Independent Living (DAIL) also sets the rates for home health services delivered under the various Medicaid waivers. In addition, DAIL sets the wages paid to waiver personal care attendants who are hired directly by Choices for Care Waiver participants. DAIL does not have a formal rate review process or methodology for rebasing and updating the payment rates for any of these Medicaid-funded home care services.

Vermont collects a tax on revenues received by provider agencies from services delivered through Medicaid, private pay, and private insurance funding, a **provider tax** similar in some

ways to the nursing home bed tax. For home health agencies, the total tax collected constitutes approximately 6 percent of their total revenue. The State earns its federal match on the taxes paid, collecting approximately $1.40 for every $1 paid to the State. These monies are added to the General Fund, in theory allowing the State to pay higher rates to providers, but there is no direct link between these two. After deducting the provider tax, the Medicaid payment rates actually received by home care agencies are about 20 percent less than the posted Medicaid reimbursement rates for all services provided for all age groups.

Under **Medicare**, home health services are more limited than under the Medicaid program. Those limitations include the requirement that Medicare beneficiaries be "homebound" and need skilled nursing or skilled therapy services.[22] Like Vermont's Medicaid nursing facility payments, the Medicare home health care payment rate is based on the "acuity" of the beneficiary. Home health care services under Medicare are reimbursed prospectively according to an acuity-based flat rate for a 60-day episode of care, which in turn is made up of multiple visits. The average payment per Medicare episode in 2004 to the Vermont agencies was $1,778.60 and $2,346 in 2005. There is also a "visit rate" which applies to "low utilization" cases where four or fewer visits are required in a two-month period (this is known as a LUPA—low utilization payment adjustment).

Medicare home health rates are determined by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services and are revised annually on a calendar-year basis. The standard prospective payment is adjusted for case-mix and geographic differences in wage levels.[23] CMS's wage index value and designation play a crucial role in the determination of the prospective payment rate for home health care and long-term care services. For example, the wage index values for home care agencies in Chittenden and Grand Isle Counties are about 22 percent lower than the wage index value for Fletcher Allen Health Care—the large community hospital located in the same area—even though the organizations compete for the same labor pool.

Provider cost structure and sector financial trends

Vermont's $90 million home health sector is operating under substantial overall financial pressure due to the confluence of several key downward pressures on revenues and upward pressures on costs. These pressures include:

- **An increase in the state provider tax on home health agencies**. Provider taxes paid by home health agencies are matched by federal funds; the tax and some of the federal match is then returned to the home health agencies as part of their rate. Even with this "return on investment," the payment received by the home health agencies remains lower than the cost of providing services. In FY 06, the provider tax on home health agencies delivering Medicaid services was increased by $1,316,105, a 39 percent increase.
- **A 4 percent decrease in Medicaid payment rates beginning in FY 2006** was authorized by the Vermont Legislature. The reduction was part of an across-the-board cut to all providers, and resulted in roughly a $270,000 loss in Medicaid home health agency revenue.
- **Substantial increase in transportation costs beginning in the summer of 2005** due to a significant increase in the per mile payments to staff traveling to client homes. Annual

transportation costs for the sector were up 11 percent through summer 2006, with most agencies increasing their 2006 mileage reimbursement rate for their employees from 40.5 cents/mile to 44.5 cents.[24]

Reimbursement Challenges

1. **Home health agencies in Vermont see a growing gap between the cost of providing care and the reimbursements they receive.** They attempt to make up the shortfall with donations and allocations from town funds.
2. **The lack of predictability about future funding levels, and the financial pressure and instability created by rate reductions and increases in the provider tax, create a disincentive for providers to invest in their workforce** through higher wages and benefits, enhanced training, and upgraded supervisory practices.
3. **The home care sector in Vermont is struggling to keep up with the higher wages that the state has elected to pay to consumer- and surrogate-directed workers and with wage levels in the hospital sector.** Recruiting and retaining sufficient staff is a problem for all home health agencies in Vermont, and the problem is most critical for the difficult-to-fill hours (evenings, weekends, and holidays).
4. **Staffing and financial pressures can be expected to increase as more Vermonters turn to home- and community-based services.**

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C. Personal Care and Supportive Services

Personal care and supportive services for older persons and persons with physical disabilities refer to assistance with activities of daily living such as bathing, dressing, toileting, mobility, eating, and dressing, and other activities that are instrumental to every day life. Services also include household or homemaker services related to needs such as food shopping, meal preparation, and light housekeeping (e.g., changing bed linens and doing laundry).

In-home personal care and supportive services for elders and persons with physical disabilities are provided by Vermont's twelve certified home health agencies and also by independent personal care attendants hired directly by consumers who qualify for one of the state's waivers,[25] or the Attendant Services Program. Recipients often depend on these services in order to continue living at home.

As detailed in Appendix 1, Vermont's in-home personal care and support services are funded through three separate funding streams: the State's General Fund, the Medicaid State Plan, and Medicaid Waivers. Personal care services provided in residential care facilities (Assistive Community Care Services) and in adult day programs (Day Health Rehabilitation Services) are covered below in Sections D and E respectively.

General Fund and Medicaid State Plan Programs

- Personal care is provided through the **Attendant Services Program** (ASP) under the General Fund as well as options under Vermont's Medicaid State Plan options, with funding from both Medicaid and the General Fund. As CMS writes, "The Attendant Services Program exemplifies Vermont's commitment to participant-directed long term care."[26] The program was started in 1983 in response to consumer demand and is designed for people 18 years and older with a permanent and severe physical disability requiring attendant services for at least two activities of daily living. Since its inception, consumers have hired, trained and supervised their own attendants, and serve as the employer-of-record. They are responsible for submitting payroll reports on a biweekly basis to a fiscal intermediary that issues workers' checks and handles all withholdings and payroll records. Initially, all ASP services were funded strictly with state General Funds. Then, in 2001, Vermont developed an ASP under the Personal Care Option of its Medicaid State Plan, permitting additional people to be served through the infusion of matching federal funds. Currently, As of May 2006, 90 of 254 ASP participants (35 percent) have their services paid for by Medicaid.
- The **Homemaker Program** serves low-income frail elders and individuals with disabilities who, absent homemaker services, would find it difficult to remain in their homes. Trained homemakers assist with meal preparation, laundry, house cleaning, errands and shopping. In addition to the traditional homemaker services, the Vermont legislature expanded this program to include a wide range of services for individuals who are Medicare eligible but who are unable to receive home care services under current federal regulations. These services include nursing case management, homemaker services or any other services necessary to maintain individuals at home when

reimbursement is unavailable from any other sources. Homemaker Services are available to the Moderate Need group under the Choices for Care Medicaid Waiver and also as a service financed by the General Fund.

- The **Children's Personal Care Services Program** (CPCS)[27] is a state-plan Medicaid service available to children under the age of 21 who have a significant disability or health condition that substantially impacts caregiving needs and/or the development of self-care skills. CSPS provides supplemental assistance with self-care and activities of daily living. Family members are allowed to be employed as caregivers.

Medicaid Waivers

- Under the newly implemented comprehensive **Choices for Care Waiver**, which started on October 1, 2005, personal care and support services are provided through three separate avenues: home health agencies, participant- or surrogate-directed caregivers, and most recently, through a new Cash and Counseling demonstration option called Flexible Choices. According to DAIL, over one-half of all personal care hours provided under this waiver in home-based settings are delivered by participant- or surrogate-directed workers who are employed by individuals who arrange for their own attendants or have a surrogate who performs this responsibility. The balance of the personal care services are provided by the twelve certified home health agencies.
- The **Traumatic Brain Injury Waiver** is designed for individuals 18 and older who have been diagnosed with a recent moderate to severe brain injury resulting in residual deficits and disability.[28] In addition to round-the-clock personal care services in a family setting, group home, supervised apartment, or in the individual's home, services also include: case management, rehabilitation, environmental and assistive technology, crisis support, respite, psychology and counseling, and employment supports.

Reimbursement Methods

Vermont employs two different rate-setting methods for in-home support and personal care services—one for agency-provided care and another for participant- or surrogate-directed care. For example, DAIL sets an hourly reimbursement rate for personal care services provided by the twelve certified agencies under the Choices for Care Waiver. The current hourly rate is $24.16 and was last revised in FY 2005, although there is no regular review process. Agency providers in turn set the wage rate and benefits paid to attendants care workers on their staff and payroll. Finally, the provider tax is also paid out of this amount.

DAIL does determine the wage rate paid to independent attendant care providers—that is, caregivers who are directly hired by personal-care program participants or their surrogates. Under both the General Fund Attendant Services Program and Medicaid Participant-Directed Attendant Care option, workers are paid $9.00/hour for the first six months of employment and then $9.50/hour after six months of employment with the same participant (wages as of 7/1/06). Workers have no paid sick or vacation leave, nor do they receive overtime wages or other benefits such as health care. Over the past 10 years, wages in this program have tended to increase 15 to 25 cents per hour in some years, usually as the result of a legislative initiative and/or pressure from advocates.

Under the Choices for Care waiver program, attendant care workers employed by consumers or their surrogates receive $10.00/hour for personal care (up from $8.50 in 2001) and $9.88/hour for respite and companion care.[29] DAIL has recently increased these wages to help draw in a larger consumer- or surrogate-directed workforce and to promote this option for consumers. Many of these paid caregivers are viewed by the State as representing a "new class of workers" that supports people needing care in their own homes and communities. The higher consumer/surrogate-directed wage was also intended to encourage wage increases for workers in the agency-managed care sector. In 2001, the prevailing wage rate paid by home health agencies was just under $8.00/hour; currently it is about $9.00/hour. According to DAIL's *Shaping the Future* report, five of eleven certified home health agencies have raised their starting wage to $10/hour for personal caregivers and many agencies provide benefits for caregivers working sufficient hours.[30] The Department is working closely with the Community of Vermont Elders (COVE) on ways to improve recruitment and retention of direct care workers through COVE's Better Jobs Better Care grant and the Vermont Association of Professional Care Providers.

Reimbursement Challenges

1. **Vermont needs to find methods for equitable and comparable wages and benefits for similar work regardless of the type of provider.**
2. **Currently, no formal methodology is used to set and increase rates for personal care and supportive services nor for Medicaid-related home health care services. It may be useful to investigate the merits of a uniform cost-based reimbursement methodology for home- and community-based services.** Among the important issues to be considered are: how would "costs" be measured, and what would it take to put such a system in place for consumers, providers and the relevant state agencies?
3. **One reimbursement strategy that Vermont could consider for enhancing the rates paid for personal care and supportive services is to pay higher rates to those providers who meet certain performance goals tied to better quality of care and higher quality jobs.**

D. Residential Care Homes, Assisted Living Residences and Enhanced Residential Care

Residential Care Homes and Assisted Living Residences are often treated as one entity; however, they are in fact subject to very different licensing requirements[31] and do not necessarily provide the same set of services. Essentially, Residential Care Homes are based on a care model while Assisted Living Residences combine housing and care services. Assisted Living Residences can receive Section 8 housing subsidies.

Residential Care Homes (RCHs) are state-licensed group-living arrangements that provide room, board, and personal care to three or more residents unrelated to the licensee (excluding licensed foster homes). RCHs are designed to meet the needs of people who cannot live independently but who usually do not require the type of care provided in a nursing facility. And, yet, these homes **may** provide nursing-facility level care to residents under certain conditions. RCHs serve a variety of clients, including elders, and persons with developmental disabilities, physical disabilities, and mental health disabilities.

Currently, there are 110 RCHs in Vermont. They are divided into two groups, depending on the level of care they provide:

- Level III homes (101 homes) do not provide full-time nursing care but instead provide room, board, personal care, general supervision, medication management, and nursing overview.[32]
- Level IV homes (9 homes) provide the same services as Level III homes but do not provide nursing overview or nursing care.[33]

In recent years, RCHs have expanded their capacity to serve people with higher levels of need. (See the description of Enhanced Residential Care (ERC) program below.) As of May 2006, there were 206 people living in RCHs who have care needs that meet the clinical criteria for nursing facility level of care and receive services through ERC. Of the 110 residential care homes in Vermont, 58 provide nursing home level services through the ERC program.

Assisted Living Residences (ALRs) refer to "a program or facility that combines housing, health, and supportive services to support resident independence and aging-in-place."[34] In contrast to RCHs, ALRs are designed to meet the needs of people who "age in place" and require the type of care provided in a nursing facility. In Vermont, they must meet RCH licensing requirements for a Level III home as well as additional requirements.[35] ALRs must retain residents at nursing-home level of care who meet any of three criteria: (i) have a score of 10 ADLs or less on the DAIL's assessment form; (ii) have a moderate or lesser cognitive impairment; or (iii) residents whose behavioral symptoms consistently respond to appropriate intervention. ALRs do not need permission from the state to retain residents at nursing home level of care; instead, by virtue of the ALR license, the facility must retain residents up to these levels.

Vermont's first ALR opened in 2003 with 28 fully accessible apartments, and today there are a total of six licensed ALRs in Vermont. Licensed assisted living is now an option in Burlington,

Rutland, Norwich, Vernon, Woodstock and Windsor. Only three of Vermont's ALRs participate as ERC providers under the Choices for Care waiver, which makes their residences more affordable to low-income Vermonters.

While RCHs and ALRs have important differences, they both receive funding from the same programs: Vermont's Assistive Community Care Services (ACCS), and the Enhanced Residential Care option under the Choices for Care waiver.

- The **Assistive Community Care Program** (ACCS) pays for Medicaid-covered services delivered to SSI recipients and Medicaid-eligible people in ALRs and Level III RCHs who need assistance with activities of daily living. The program was implemented in FY 2000 as part of Vermont's Medicaid State Plan. Services include: case management; assistance with activities of daily living; medication assistance monitoring and administration; 24-hour on-site assistive therapy; restorative nursing; nursing assessment; health monitoring; and routine nursing tasks. Staff members are supervised by a State-Certified Manager and licensed Registered Nurse. Eighty-four percent of RCHs (or 92 homes) accept ACCS payments. To be eligible for ACCS, an individual must need the level of care provided by a Level III RCH or ALR, and must be financial eligible for community-based Medicaid.
- The **Enhanced Residential Care** (ERC) Program helps pay for care in an alternative community setting for people who qualify for admission to a nursing facility and who meet long-term care financial eligibility requirements. ERC—which is now part of the Choices for Care waiver—provides services to individuals residing in RCHs (Level III) and in ALRs, when approved by DAIL. ERC provides: nursing overview, personal care services, case management, medication assistance, recreational and social activities, support for individuals with cognitive impairments, and 24-hour on-site supervision. Services must be provided in non-institutional, home-like settings. Currently, 214 Choices for Care participants use the ERC program. As of May 2006, there were 206 people in residential care homes receiving ERC and another 8 participants living in Assisted Living Residences.

The state projects significant growth in the number of people using ERC and ACCS over the next five to seven years. DAIL's 2006 report—*Shaping the Future of Long Term Care and Independent Living*—forecasts a 36 percent growth in ERC participants from 2005 to 2010 and a 26 percent increase in ACCS.[36] It should be noted that, as this study went to print, the current number of ERC participants had nearly reached the number projected for 2010 (247).

Reimbursement Methods

ERC rates returned to a very simple "acuity-based" model using three "tiers" or levels of care need. Residential care and assisted living care are reimbursed on a per diem rate basis, according to the resident's assessed level of need. The current reimbursement rates for ERC residents in RCHs are $47 per day, $53.50 per day and $60.00 per day, depending on the care needs of the individual. The reimbursement rates for ERC residents in ALRs are $52.00 per day, $58.50 per day, and $65.00 per day, depending on the care needs of the individual.

The ACCS rate of $33.25 per day (effective July 1, 2006) is added to the ERC rate, bringing the total per diem amount received for each individual residing in an RCH to $80.25 per day, $86.75

per day, and $93.25 per day. For ALRs, the combined rates are $85.25 per day, $91.75 per day, and $98.25 per day.

The ERC tiered rate system was developed by DAIL using data from an ERC assessment tool and a review of other state reimbursement systems. No regular review of ERC rates by DAIL is required. ACCS rates are set by DAIL, based on additional legislative appropriations; there is no specified regular review process nor a built-in cost of living adjustment. As a result, ACCS providers must request an increase every year. Although since the 2000 legislative session there have been modest increases every year except one (2005), the end result is unpredictable and requires many hours of provider time just to keep pace with inflation.

Provider Cost Structure

The ACCS and ERC Medicaid rates only reimburse RCHs and ALRs for personal care and nursing services. In RCHs, all other costs–including meals, and all housing costs associated with the residential structure and operations (insurance, maintenance, taxes, debt service, etc)–are paid by the resident. Similarly, ALRs have no subsidy source for their meals program. ALRs may accept federal Section 8 rental assistance towards the housing costs of eligible residents. All Medicaid residents in these settings are protected by caps on the percentage of their income that can be claimed by the RCH or ALR for meals and housing costs. While these caps protect the very modest incomes of residents, they also limit the facility's ability to cover non-health care related costs.

Reimbursement Challenges

1. **For all practical purpose, Assisted Living Residences currently are operating under a risky, unfunded mandate.** Assisted Living Residences are prohibited from discharging anyone before they reach the highest ADL score for care needs, thus protecting the housing stability of ALR residents and allowing them to age in place as the need for assistance increases. However, when this consumer right is coupled with the current reimbursement methodologies, ALRs must absorb considerable risk. In contrast, RCHs may discharge residents under the same set of circumstances with residents losing their right to "age in place" and presumably being directed to nursing facilities. Because Vermont needs to control expenditures in the Choices for Care waiver, it has not yet made an absolute commitment to fund ALR and RCH residents when they become "High Need," but rather only when they reach the "Highest Need" level.
2. **The fundamental logic and success of the new Choices for Care waiver depends on the continued vitality of RCHs and ALRs in Vermont, yet the lack of capacity in this sector of Vermont's long-term care system limits where eligible Vermonters can live *and* receive services. RCHs and ALRs** are not "nice to have" options but rather vital components of the long-term system envisioned by the new waiver.
3. **The public reimbursement structure for residential care and assisted living acts as a strong disincentive for new providers to enter the system.** In 2004, DAIL reported that nine entities were actively planning Assisted Living projects, but two years later only five such projects under consideration. Furthermore, many RCHs are in need of capital improvements, including safety upgrades, while ALRs tend to be newly renovated. The current reimbursement method does not provide for capital improvements related to the physical infrastructure of Vermont's RCHs and ALRs.

4. **Because of their low reimbursement levels, ALRs and RCHs encounter difficulty staffing their facilities.** They often are unable to offer competitive wages and salaries for resident assistants, nursing staff, and resident service coordinators. As a result, some facilities may be understaffed and retention can be problematic.
5. **Out of House (OOH) rules create a Catch 22**. ALRs and RCHs are subject to OOH rules which provide that, whenever a Medicaid recipient is out of the residence for 24 hours or more, regardless of the reason (hospitalization or vacation), the residence no longer receives ACCS or ERC reimbursement. This policy can create a disincentive for RCHs to "hold the bed"; however, for ALRs required to retain residents, this nonpayment poses a Catch 22: the ALR must maintain staffing levels and keep the apartment available, yet OOH rules can lead to significant revenue losses, particularly during flu season.
6. **A comparison of ALR rates and Medicaid nursing home rates shows variability in payment rates for same/similar services.** The expectation of ALRs in Vermont is that individuals will be permitted to age in place. ALR regulations prohibit ALRs from involuntarily discharging a resident until their care needs rise to the following levels: (a) an ADL score above 10; (b) a cognitive impairment that is higher than a moderate degree of severity; or (c) behavioral symptoms that do not consistently respond to appropriate interventions. Even if the ALR determines that the reimbursement rate is not sufficient to cover the care of an individual below these levels, the ALR is obligated to continue to care for the resident. If the individual then moves to a nursing home, the average daily cost for a Medicaid-resident is $156/day. The human cost of a move near the end of life, coupled with the additional financial cost, suggest that a rate somewhere in between $98.25 and $156/day may actualize the ability of ALRs to retain residents needing nursing home level of services.

E. Adult Day Services

Adult day services play a key role in helping many frail elders, adults with disabilities and/or dementia, and individuals undergoing rehabilitative care, to remain independent and at home. According to DAIL, "nearly half (47.3 percent) of adult day program attendees have a diagnosis of a cognitive impairment and over one quarter (25.8 percent) have a diagnosis of Alzheimer's Disease or a related disorder."[37]

In Vermont, adult day centers offer full-day health-based services and supervision of participants while furnishing much needed respite to family caregivers. The centers currently offer supervision of activities of daily living (including assistance with personal hygiene and bathing), medication administration, therapeutic activities, personal care and professional nursing services, activities, socialization opportunities, and hot nutritious meals. In addition, adult day centers also have the obligation under State standards to either provide, or make available, professional social work, nutritional services, and physical, occupational, and speech therapy.

Like other long-term care options, adult day services have undergone a considerable metamorphosis over the last decade. Adult day services used to be structured programs that provided brief respite to families caring for an older person or individual with a disability. Arts and crafts programs were offered along with recreational activities. A nurse would perhaps visit for a few hours a day. Today, Vermont's adult day programs are adult day *health* centers, which incorporate both social and medical services. Since January 2004, these programs are subject to substantially more stringent *Standards for Adult Day Services in Vermont*[38].

Adult day services are delivered by 14 certified organizations with 17 sites across the state. Most of the organizations are small, non-profits. These organizations have experienced steady growth in both the number of persons served and the quality and quantity of services provided, reflecting an increase in the acuity needs of the program participants.

In SFY 2005, Vermont's certified adult day programs provided 440,852 units of service[39] to 1,027 individuals. This represented a 17 percent increase from the number of individuals who received services in 2001 and a 19.7 percent increase in the number of units of service provided.[40] In the first three quarters of SFY06, the centers served 1,015 individuals. This is close to the number of participants served during the entire previous year. Daily attendance ranges from nine individuals a day in the smallest center to up to 70 people a day in the largest center, with average attendance around 28 persons a day. DAIL projects a 26 percent growth in adult day participants between 2005 and 2010 and a 22 percent growth from 2010 to 2015.[41]

In 2000, the Vermont State Legislature appropriated $500,000 in one-time funding to support infrastructure enhancement for Vermont's Adult Day Programs. A handful of centers were awarded grants to assist them in building their capacity in a variety of ways; including moving to new, larger facilities, renovating and expanding existing facilities, and purchasing necessary furniture and equipment.

Adult day services are funded through DAIL's **Adult Day Program,** which in turn receives funding from the State General Fund, the new Choices for Care waiver, and the **Day Health Rehabilitation Services** (DHRS) Program which is a Medicaid State Plan service.[42] Services provided under DHRS include: health assessment and screening, health monitoring and education, skilled nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling and services. Participants must require services in at least two of the following broad service areas: assistance with personal care, nursing services, special therapies, social work, and nutrition counseling and services.

Eligibility

Choices for Care waiver Highest and High Need participants attending adult day programs must qualify for nursing facility level of care. Waiver "Moderate Need" participants must meet a lower clinical and financial threshold to qualify for payment of adult day services. Many participants from the Moderate Group have care needs that would make them eligible for the Highest or High Need groups but they do not meet the financial eligibility. DHRS participants must require services in at least two of the following broad service areas: assistance with personal care; nursing services; special therapies; and social work and nutrition counseling and services. State General Funds are now distributed among the centers as base funding to provide general support for the adult day centers, but are no longer specifically used to support individual participants.

Reimbursement Methods

Adult day centers receive base funding from General Funds through DAIL using a formula that takes into consideration basic operations, and past utilization. In addition, centers that are certified to be in compliance with state standards may also enroll as Medicaid providers of Day Health Rehabilitative Services (DHRS) under the new Global Commitment to Health Waiver.

Rates for all Highest, High, and Moderate participants under the Choices for Care Waiver (which started October 1, 2005) and DHRS participants increased to $12.00 per hour on July 1, 2006. The $12 per hour rate is inclusive of most services.[43] There is no mandated regular review schedule or process regarding rate setting. Prior to this increase, participants with the Highest and High levels of need were reimbursed at $11.20 per hour, and those at the Moderate need level at $11.00 per hour. Those rates were last increased in July 2003 (up from $10.20 and $10.80, respectively).

For individuals who are not eligible for existing public programs, access to services is available according to sliding-fee scales based on the income of the client.

Provider Cost Structure and Sector Financial Trends

The average hourly cost reported by adult day service providers ranges from $13 to $16, or up to 30 percent more than current reimbursement rates. Providers attempt to make up this substantial gap between costs and reimbursement through time-consuming, local community fundraisers, such as yard sales, bake sales, and a variety of raffles. They also try to attract more private-pay participants and solicit bequests from families.

Licensed nursing assistants (LNAs) in some Adult Day Centers are paid just under $10 per hour, lagging behind the wages received in other long-term care settings.[44]

Adult day centers must set aside portions of their net revenue, if any if available, to finance repairs and maintenance to physical infrastructure in addition to the ever-increasing other costs of providing services.

Reimbursement Challenges

1. **Providers of adult day services report that the Medicaid reimbursement rates they receive do not cover their actual costs, and, as a result, substantial resources are diverted into private fundraising as a means to manage operating deficits.**
2. **The reimbursement rates paid to adult day centers do not include a "cost center" for improvements or depreciation.** One hundred percent of the rate is allocated to operating costs, making it difficult to maintain much less improve the physical structure of these centers.
3. **The adult day sector is at a competitive disadvantage relative to other long-term sectors because of its lower wage scale.** According to the Vermont Association of Adult Day Services, the wages and benefits received by direct-care workers in adult day programs are less than those received in other long-term care settings, resulting in a competitive disadvantage for the adult day sector relative to other settings.
4. **Changing demographics and consumer preferences are driving the need for more adult day centers and expanded services, including extended weekend and evening hours. However, most organizations are barely staying afloat now and do not have the resources to expand.**
5. **Increased transportation costs also are adversely affecting the already overextended budgets of adult day centers.** The State's Elderly and Disability Transportation program is currently administered by the Department of Transportation. Adult day centers receiving sub-funding via this program are in direct competition with other human services providers as well as municipalities for the limited available dollars. Medicaid covers transportation costs only for Choices for Care Highest and High Category participants and DHRS participants. Choices for Care Moderate Need Category participants as well as all other adult day participants are not eligible for Medicaid-funded transportation.

V. Challenges and Opportunities for Vermont's Long-Term Care Reimbursement Systems

Vermont has elected to realign and manage its long-term care services as a system rather than as a random collection of uncoordinated individual services or bundles of pre-ordained services. Two of the most important goals of the new 1115 Choices for Care waiver are, first, to provide Vermonters with choice and equal access to either nursing facilities or care in home- and community-based settings, and, second, to serve more people while better managing the costs of long-term care and developing a more balanced long-term care system.

This review suggests that Vermont lacks a reimbursement structure for its long-term care services that is aligned with and supports the programmatic and fiscal goals of its new Choices for Care waiver. With the exception of nursing facilities, the approach for setting the rates in nearly all of Vermont's public long-term care programs is *ad hoc*: that is, there is no state commitment to regularly review and either rebase and/or update the rates, and the State has no explicit systematic method for setting, rebasing or updating the rates. As a result, rates are largely established in response to improvement or deterioration in the State's fiscal condition, and in response to targeted provider, worker, or consumer advocacy efforts. Such an approach does not allow for evaluating the adequacy of rates over time based for example, on information about the current costs of providing services.[45]

Among the specific reimbursement problems revealed by this review are:

- Lack of reimbursement parity for the same services conducted within and across settings.
- Absence of a comprehensive, integrated reimbursement rate-setting methodology across all long-term care settings.
- Lack of regular rate reviews that systematically take into account current financial, economic, and program utilization data, labor costs and other information relevant to setting rates and evaluating their adequacy over time.

Without exception, providers in all of Vermont's care settings report that current reimbursement rates fall short of the actual cost of providing care and that the gap has been growing. When this gap is perceived as being unmanageable, providers are likely to "exit" the system, weakening the provider infrastructure, reducing consumer choice, disrupting services, and creating job losses.

Moreover, new providers are deterred from "entering" the system. A case in point is Assisted Living Residences—Vermont currently is having difficulty attracting the development of new affordable assisted living residences, despite the considerable demand for this type of housing and supported services.

To offset reimbursement rates that are lower than the cost of services, providers have a strong incentive to shift unreimbursed public costs to long-term care recipients who are privately insured and to those who pay out of their own funds. Alternatively, they can decline to take Medicaid recipients, or they can cut back on charity care. Finally, the budgets of many of Vermont's non-profit provider organizations depend heavily on donations and successful charity

fundraising, activities which can take valuable time and focus from delivering supports and services.

Ad hoc, piecemeal approaches to program reimbursement have an adverse effect on providers if only because they undermine the ability to plan ahead, a key ingredient of any successful business. Providers are continually concerned about the instability of the state's commitment to adequately reimburse providers for the services that the state has authorized or required them to provide. This uncertainty is detrimental to the ability of providers to invest in their workforces—to provide upgraded training, to invest in improved supervisory practices, and to offer better wages and benefits—because it increases the risks of adopting a more expensive cost structure that may not be covered by reimbursement. From the vantage point of consumers, these business decisions have a profound impact on their access to care in different long-term settings and on the actual quality of services they receive.

Relying *solely* on annual appropriations and budget decisions by the state, instead of incorporating systematic and consistent reimbursement methods across the various long-term programs may also adversely impact the ability of Vermont to achieve its overarching rebalancing goals. In general, providers report a hierarchy of competitive salaries, wages, and benefits across different provider types that is biased toward institutional service settings, such as hospitals. This hierarchy is principally due to the fact that different payment systems support each of these providers even though they may be delivering the same services. For example, considering paraprofessional workers, a Vermont LNA employed in a hospital receives the most competitive compensation. Next in the hierarchy are nursing homes, followed by home health agencies. At the bottom are congregate and supported living facilities and adult day programs. As a recent report about community-based long-term services in Rhode Island concluded, "[o]verall, hourly wages and employee benefits decline on the provider continuum as it moves from institutional care toward community care and home care."[46]

The existence of a non-level "playing field" with respect to the ability of providers to compete for and retain qualified staff is likely to impede Vermont's system-wide rebalancing goals. This is because these goals are predicated on a steady expansion of Vermont's home- and community-based services to serve an increasing number of elderly individuals and individuals with physical disabilities in non-nursing home settings. But this expansion will be constrained to the extent that home- and community-based providers have difficulty offering competitive compensation to their workforce.

Opportunities for Improving Vermont's Reimbursement Systems for Long-Term Care
Vermont is at the vanguard of rebalancing efforts in the United States and faces a unique opportunity to develop a reimbursement structure for its long-term care programs commensurate with these reform efforts. A comprehensive, integrated reimbursement structure is essential to:

- Ensure provider participation within state budget constraints;
- Develop rates that support quality care, aging-in-place, and self-direction; and
- Achieve balance and access across and between these settings and services.

Potential ingredients of an improved reimbursement approach might include the following:[47]

1. An integrated approach to setting rates across the state's full array of long-term care supports and services that promotes rebalancing and addresses problems created by unrelated, uncoordinated, and inconsistent setting of rates across departments, settings, and programs.
2. Consistent and uniform standards and data to guide the setting of rates across services and settings.
3. Models for setting rates that allow for the evaluation of the adequacy of rates over time.
4. Rate enhancement models (e.g., pay for performance, tiered reimbursement strategies) that target policy and program goals to be achieved through higher performance standards related to quality care and quality jobs.

Long-term care reimbursement rates play a vital role in promoting efficiency and economy, and in ensuring sufficient provider capacity to produce and deliver the quality of services needed, including adequate numbers of well-trained direct care workers. The need for an overarching structure that sends the "right" signals about reimbursement could not be more pressing as Vermont undertakes systemic reforms to provide more effective, accessible, and affordable long-term care services.

APPENDICES

Appendix 1 Vermont's Publicly Funded Long-Term Care Programs

Appendix 2 Methods for Determining Reimbursement in Vermont's Long-Term Care Programs

Appendix 3 Comparing Rates and Services Across Vermont's Long-Term Care Programs

Appendix 4 COVE Long Term Care Workforce Policy Committee

Appendix 1: VERMONT'S PUBLICLY FUNDED LONG-TERM CARE PROGRAMS

LTC PROGRAM	Participants	Public Revenue Received by Organization	Number of Facilities/Sites (2006)
Nursing Home Care			
Total (does not include private pay funds)	Unduplicated number not available	$161,311,933 (FY05)	43
Medicare	3,619 (4/1/05-3/31/06)	$45,438,129	41
Medicaid (part of Choices for Care as of 10/1/2005)	3,032 (4/1/05-03/31/06)	$115,873,804 (FY05)	40
Home Health Care (Non-profit agencies only)	FY03	FY03	
Total	21,375**	$85.4 million***	12 agencies
Medicare	9,500	$42.9 million	12 agencies
Medicaid State Plan	5,800	$15.2 million	12 agencies
• High Tech Services (includes the for-profit agency)	FY05 86	FY05 $4,635,356	12 agencies
Medicaid Waiver			
• Choices: Agency-directed	835	$11.8 million	12 agencies
In-Home Personal Care & Supportive Services	SFY05 unless otherwise noted	SFY05 unless otherwise noted	
General Fund			
• Attendant Services Program (Participant-Directed)	163	$3,448,283	NA
• Homemaker Program (no SSBG funds)	851	$801,471	12 agencies
Medicaid State Plan			
• Attendant Services Program (Participant-Directed)	90	$181,364*	NA
• Children's Personal Care Services (Agency- and Family-Directed)	1,296 (FY05)	$12,291,823 (FY05)	No sites, but 28 provider agencies as of 7/1/06
Medicaid Waiver			
• Choices: Agency-directed (SFY05)	835	$11,770,999	12 agencies
• Choices: Participant-directed (SFY05)	257	$2,572,983	NA
• Choices: Surrogate-directed (SFY05)	714	$7,857,047	NA
• Choices: Flexible (as of July 2006)	NA	NA	NA
• Traumatic Brain Injury	49 (FY06)	$2,473,959 (FY04)	21 providers as of 7/1/06
Residential Care	SFY05	SFY05	
Total (not including private pay)	Not available (Total licensed beds 2,279)	$31,728,699	110
Medicaid State Plan			
• Assistive Community Care Services (ACCS)	1,068 (FY05)	$9,280,099	79
Medicaid Waiver			
• Enhanced Residential Care (now part of the Choices for Care Waiver)	531	$2,553,823	58
Assisted Living	SFY05	SFY05	
Total		$313,059	6
Medicaid State Plan			
• Assistive Community Care Services (ACCS)	26	$166,354	3
Medicaid Waiver			
• Enhanced Residential Care (now part of Choices Waiver)	17	$146,705	3

Appendix 1: VERMONT'S PUBLICLY FUNDED LONG-TERM CARE PROGRAMS

LTC PROGRAM	Participants	Public Revenue Received by Organization	Number of Facilities/Sites (2006)
Adult Day	FY05	FY05	
Total			14 organizations (17 sites)
General Fund			
• Adult Day Program (as of 10/1/05, GF does not specifically fund individual participants; provides base funding only)	397	$1,038,786	
Medicaid State Plan			
• Day Health Rehabilitation Services (DHRS)	202	$1,278,090	
Medicaid Waiver (Choices for Care) *	143	$1,418,954	

* Partial year start-up
** Not an unduplicated count. Some participants are covered by more than one payment source.
***Reflects revenue sources in addition to Medicare and Medicaid.

Appendix 2: METHODS FOR SETTING REIMBURSEMENT IN VERMONT'S LONG-TERM CARE PROGRAMS

Type of LTC Service	Current Rate	Last Revision to Base Rate	Last Update to Rate	Rate Review Process	Reimbursement Rate Methodology
Nursing Home Care					
Medicare	$149.87-$582.52/day - rural $145.83-$539.53/day - urban (very few payments at low and high ends)	January 2006	January 2006	Rates are set by CMS. Revised annually on calendar year basis.	Acuity-based prospective payment system using case mix weights for 53 Resource Utilization Group (RUG) categories based on the specific resident needs and adjusted for rural/urban differences.
Medicaid Waiver (Choices for Care)	$156.40/day (average for 2006)	January 2005 (based on 2002 cost data)	October 2006	Nursing care costs are rebased no less frequently than once every three years and for other costs no less frequently than once every four years, unless the Secretary of the Agency of Human Services, on the advice of the Director of the Division of Rate Setting, certifies to the General Assembly that rebasing is unnecessary or a modification of these provisions is authorized by statute. In non-rebase years, rates are trended forward with inflationary factor.	Acuity-based prospective payment system using case mix weights with 44 patient classifications. Allowable cost centers: nursing care, resident care, indirect costs, DON, property, & ancillaries. Cost ceilings: • Nursing Care – median + 15% • Resident Care – median + 20% • Indirect Care – median • DON – 100% • Property – 100% • Ancillaries – 100% • Certain hospital based facilities are at median plus higher percentage rates for nursing care, resident care and indirect costs Facilities with less than 90% occupancy penalized (changing for SFY 2007 only.) Wage supplement payments expired Dec. 31, 2004.

Appendix 2: METHODS FOR SETTING REIMBURSEMENT IN VERMONT'S LONG-TERM CARE PROGRAMS

Type of LTC Service	Current Rate	Last Revision to Base Rate	Last Update to Rate	Rate Review Process	Reimbursement Rate Methodology
Home Health Care					
Medicare	$2,346 on average per 60 day event/individual) (FY05)	April 2006	April 2006	Rates are set by CMS. Revised annually on calendar year basis.	Prospective payment according to acuity-based flat rate for 60-day episode of care. Low-utilization cases receive a "visit rate." Payments are adjusted for case-mix and geographic differences in wage levels.
Medicaid State Plan					
• Physical Therapy • Occupational Therapy • Speech Therapy • Skilled Nursing • Medical Social Services, General	Rates per hour: $98.96 $99.62 $107.54 $92.06 $145.10	NA	July 2005 Current rates reflect a 4% across-the-board reduction made by the Legislature in 2005.	Rates set by OVHA; no formal review process. Legislature decides final funding.	Rates vary by type of service but not by acuity of client. No systematic method used to rebase or update rate.
• High Tech Services	Skilled nursing (rates/ hr) Weekday Weekend Day $34.08 $38.04 Eve $36.64 $40.36 Night $41.28 $51.48 Hi Tech Aide Weekday Weekend Day $22.00 $23.60 Eve $22.80 $24.80 Night $24.40 $26.40 Nursing assessment: $65.60/visit (limit 1 visit/month) Initial care plan development: $57.50/hr for up to 3 hours Nursing blood draw: $52.50/visit	NA	Skilled nursing last updated July 2006 High Tech Aide last updated July 2006 Last updated Sept. 2002 Last updated Jan. 2001 Last updated Jan. 2001	Rates set by DAIL; no formal review process.	No systematic method used to rebase or update rate. Any increases are dependant on additional dollars appropriated by Legislature.

Appendix 2: METHODS FOR SETTING REIMBURSEMENT IN VERMONT'S LONG-TERM CARE PROGRAMS

Type of LTC Service	Current Rate	Last Revision to Base Rate	Last Update to Rate	Rate Review Process	Reimbursement Rate Methodology
In-Home Personal Care & Supportive Services					
State Funded					
• Participant-Directed Attendant Care	$9.00/hr for first 6 mos. with the same participant; then $9.50/hr	NA	July 2006	Wages are set by DAIL. No formal review process.	Any increases are dependant on additional dollars appropriated by Legislature. Decision then is whether to increase wages or add more participants to the program.
• Homemaker Program	$16/hr	NA	2004	Rates set by DAIL. No regular review process.	Any increases are dependant on additional dollars appropriated by Legislature.
Medicaid State Plan					
• Participant-Directed Attendant Care	$9.00/hr for the 6 mos. with the same participant; then $9.50/hr	NA	July 2006 Legislature gave a $1/hr increase starting July 1, 2006	Wages set by DAIL. No formal review process.	Any increases are dependant on additional dollars appropriated by Legislature. Decision then is whether to increase wages or add more participants to the program.
• Children's Personal Care: Agency-directed	$13.52/hr	NA	July 1999 (slight increase from $13.50 to current rate when billing went to quarter hour units)	Rates set by DAIL & OVHA. No regular review process.	No systematic method used to rebase or update rate.
• Children's Personal Care: Family-directed	$11.36/hr	NA	July 2006	Rates set by DAIL & OVHA. No regular review process.	No systematic method used to rebase or update rate.
Medicaid Waiver					
• Choices for Care: Agency-directed Personal Care	$24.16/hour Includes the provider tax.	NA	April 2006	Rates set by DAIL. No regular review process.	No systematic method used to rebase or update rate.
• Choices for Care: Participant/surrogate-directed Personal Care	$10.00/hr for personal care; $8.50/hr for respite & companion care	NA	April 2006	Rates set by DAIL. No regular review process.	No systematic method used to rebase or update rate.
• Choices for Care: Agency-directed Respite & Companion	$20.00	NA	October 2005	Rates set by DAIL. No regular review process	No systematic method used to rebase or update rate.
• Choices for Care: Consumer/Surrogate-directed Respite & Companion Services	$9.88	NA	April 2006	Rates set by DAIL. No regular review process	No systematic method used to rebase or update rate.

Appendix 2: METHODS FOR SETTING REIMBURSEMENT IN VERMONT'S LONG-TERM CARE PROGRAMS

Type of LTC Service	Current Rate	Last Revision to Base Rate	Last Update to Rate	Rate Review Process	Reimbursement Rate Methodology
• Choices for Care: Homemaker (for moderate need group)	$18/hr	NA	October 2005	Rates set by DAIL. No regular review process	No systematic method used to rebase or update rate.
• Choices for Care: Flexible Choices (start date 7/24/06)	Participants negotiate wages they are willing to pay.	NA	NA	NA	Negotiated by the participants, with assistance from the consultants as needed. (Vermont uses the term "consultant" rather than counselor for the person who helps participants.)
• Traumatic Brain Injury	27 different billing codes for various services provided. Some are hourly, some are per day.	NA	Oct. 2001 for case management, Preadmission Planning, 24-hour Community Support & Respite	Rates set by DAIL. No regular review process.	No systematic method used to rebase or update rate.
Residential Care					
Medicaid State Plan					
• Assistive Community Care Services (ACCS)*	$33.25/day	NA	July 2006 a $3/day increase	Rates set by DAIL. No regular review process.	No systematic method used to rebase or update rate. Increases based on additional legislative appropriations.
Medicaid Waiver					
• Enhanced Residential Care	Per day rates:** Tier 1 $80.25 Tier 2 $86.75 Tier 3 $93.25	NA	ACCS rates increased to $33.25 on 7/1/06, which added $3 to each ERC Tier.	Fairly predictable increases, but no required review.	Tiered rate system determined by DAIL. Developed using ERC assessment tool, review of other state reimbursement systems, and assessment data. Residents receive scores in 5 areas. Resulting score results in assignment to ADL Level 1 or 2. Within each level, there are 3 payment tiers.
Assisted Living					
Medicaid State Plan					
• Assistive Community Care Services (ACCS)*	$33.25/day	NA	In July 2006, a $3/day increase	Rates set by DAIL. No regular review process.	Increases are determined by Legislature. No systematic method used to rebase or update rate..
Medicaid Waiver					
• Enhanced Residential Care	Per day rates:** Tier 1 $85.25 Tier 2 $91.75 Tier 3 $98.25	NA	In July 2006, a $3/day increase	Rates set by DAIL. No regular review process	No systematic method used to rebase or update rate.

Appendix 2: METHODS FOR SETTING REIMBURSEMENT IN VERMONT'S LONG-TERM CARE PROGRAMS

Type of LTC Service	Current Rate	Last Revision to Base Rate	Last Update to Rate	Rate Review Process	Reimbursement Rate Methodology
Adult Day Services					
State Funded					
• Adult Day Program	Programs utilize sliding fee scale structure (base funding may be used to support sliding fee scale).	NA	July 2006	No regular review process	Rates are determined by individual providers, although programs must submit their sliding fee scales to DAIL for approval. As of SFY07, the amount of General Fund dollars allotted to providers is based on two factors: 1) flat dollar amount, and 2) previous levels of service provided.
Medicaid State Plan					
• Adult Day Program Day Health Rehabilitation Services	$12/hr	NA	July 2006	Rate set by DAIL. No regular review process	No systematic method used to rebase or update rate.
Medicaid Waiver (Choices for Care)					
• Adult Day Services	$12/hr	NA	July 2006	Rate set by DAIL. No regular review process	No systematic method used to rebase or update rate.

* Level III Residential Care Homes and Assisted Living Residences bill a room and board fee to residents whose care is paid for by Medicaid. For residents sharing a room, the room and board fee may be no more than the federal portion of the SSI rate which is currently $603.00 per month. The resident must be allowed to retain a personal needs allowance of at least $47.66. If the resident has a private room/apartment and income above the SSI rate, the home/ALR may charge up to 85% of the resident's income. The resident must be allowed to retain a personal needs allowance of $47.66. All residents must spend down to the PIL (Protected Income Level) to be eligible for Medicaid. Choices for Care/Enhanced Residential Care participants may have up to $908 in income. If the participate is in a private room, the home may charge the resident a room and board fee of no more than $771.80 (85% of $908). Resident rooms and ALR apartments are considered private when they are occupied by a household of one or a household of two comprised of a couple (spouses or civil union partners or relatives). This does not apply to Community Rehabilitation and Treatment (CRT), Developmental Services (DS) or Traumatic Brain Injury (TBI) residents.
** Rates are the sum of the ERC rate and the ACCS rate, since providers receive both.

Appendix 3: COMPARING RATES & SERVICES ACROSS VERMONT'S PUBLICLY FUNDED LONG-TERM CARE PROGRAMS

LTC PROGRAM	CURRENT PUBLIC RATE	SERVICES COVERED BY RATE
Nursing Home Care		
Medicare	\$149.87 - \$582.52 rural (per day) \$145.83 - \$539.53 urban (per day) (very few at far lowest and highest ends)	Semi-private room, meals, skilled nursing care, physical therapy, occupational therapy, speech/language therapy, medical social services, medications, medical supplies & equipment used in facility, ambulance transportation, dietary counseling.
Medicaid Waiver (Choices for Care)	\$156.40/day (average. for 2006- VT Division of Rate Setting)	Medical & nursing care, personal care, case management, meals, housing/ property-related expenses.
Home Health Care		
Medicare	\$2,346 on average per 60-day event/individual) (FY05)	Medicare-approved services, e.g., nursing aides, therapies
Medicaid State Plan		
• Physical Therapy • Occupational Therapy • Speech Therapy • Skilled Nursing • Medical Social Services, General	Rates per hour (7/1/05): \$98.96 \$99.62 \$107.54 \$92.06 \$145.10	
• High-Tech Services	Skilled nursing (7/1/06 rates /hr) Weekday / Weekend Day \$34.08 / \$38.04 Eve. \$36.64 / \$40.36 Night \$41.28 / \$51.48 Hi Tech Aide (7/1/06) Weekday / Weekend Day \$22.00 / \$23.60 Eve. \$22.80 / \$24.80 Night \$24.40 / \$26.40 Nursing assessment \$65.60/visit – limit 1 visit/month Initial care plan development \$57.50/hr for up to 3 hours Nursing blood draw \$52.50/visit.	Case management, skilled nursing,
In-Home Personal Care & Supportive Services		
State Funded		
• Participant-Directed Attendant Care	\$9.00/hr 1st 6 mos. Then \$9.50/hr (SFY07)	Assistance with ADLs and IADLs
• Homemaker Program	\$16/hr (SFY05)	Meal preparation, laundry, house cleaning, errands and shopping or any other services necessary to maintain individuals at home when reimbursement is unavailable from any other sources.

Appendix 3: COMPARING RATES & SERVICES ACROSS VERMONT'S PUBLICLY FUNDED LONG-TERM CARE PROGRAMS

Medicaid State Plan		
• Participant-Directed Attendant Care	$9.00/hr & $9.50/hr (SFY07)	Assistance with ADLs and IADLs
• Children's Personal Care: Agency-directed • Children's Personal Care: Family-directed	$13.52/hr (SFY05) $11.36	Assistance with ADLs, meal prep, monitoring vital signs, skin care, assistance with positions, lifting, transferring, ambulation and exercise, teaching new skills.
Medicaid Waiver		
• Choices for Care: Agency-directed - Personal care - Respite care - Companion care	$24.16/hr (SFY05) $20/hr $20/hr	Assistance with ADLs and IADLs • Personal care • Respite Care (personal care, supervision, socialization) • Companion Care (limited personal care or household tasks, supervision, socialization)
• Choices for Care: Participant/surrogate-directed - Personal care - Respite care - Companion care	$10/hr/ $9.88/hr $9.88/hr* * If delivered through Senior Companion Program, rate is $7.52	Assistance with ADLs and IADLs. • Personal care • Respite Care (personal care, supervision, socialization) • Companion Care (limited personal care or household tasks, supervision, socialization)
• Choices for Care: Flexible Choices	NA Consumers set wages.	Flexible use of funds to meet care needs.
• Choices for Care: Homemaker (a service for the Moderate Need Group)	$18/hr	Services related to needs such as food shopping, meal preparation, and light housekeeping.
• Traumatic Brain Injury	Many rates depending on the specific service: - Case management $36/hr - Rehab $20.50 - Community Supports - $62.50/day - Respite - $62.50/day - Environmental & assistive technology $4,000 in a lifetime - Crisis Support $500/day - Psychology & Counseling $65/day - Employment Support - $20.50/hr - Pre-admission planning - $36/hr	Case management, rehabilitation, community supports, respite, environmental and assistive technology, crisis support, psychology and counseling, employment support, and pre-admission planning,
Residential Care		
Medicaid State Plan		
• Assistive Community Care Services (ACCS)	$33.25/day	Case management, assistance with ADLs, medication assistance monitoring & administration, 24-hour on site assistive therapy, restorative nursing, nursing assessment, health monitoring, routine nursing tasks.
Medicaid Waiver		
• Enhanced Residential Care	Per day (SFY07): Tier 1 $80.25 Tier 2 $86.75 Tier 3 $93.25	Nursing overview, personal care services, case management, medication assistance, recreational & social activities, support for individuals with cognitive impairments, 24-hour on-site supervision.

Appendix 3: COMPARING RATES & SERVICES ACROSS VERMONT'S PUBLICLY FUNDED LONG-TERM CARE PROGRAMS

Assisted Living		
Medicaid State Plan		
• Assistive Community Care Services (ACCS)	$33.25/day (SFY07)	Case management, assistance with ADLs, medication assistance monitoring & administration, 24-hour on site assistive therapy, restorative nursing, nursing assessment, health monitoring, routine nursing tasks.
Medicaid Waiver		
• Enhanced Residential Care	Per day: Tier 1 $85.25 Tier 2 $91.75 Tier 3 $98.25 (SFY07)	Resident care and case management covered by the rate. Nursing overview, personal care, medication management, laundry services, household services, case management services and health rehabilitative and supportive services. Daily social and recreational activity opportunities.
Adult Day		
General Fund		
• Adult Day Program	Programs utilize a sliding fee scale. Rates range from $1.35 - $16/hr. (Very few participants at the highest end.) Base fund supplements sliding scale revenue. $25,000 + % based on units of service provided previous year. Current statewide % range: $1,300-$24,691/yr.	Meals, bathing, skilled nursing services, medications administration, activities, check-up, vital signs, diabetic stick, etc.
Medicaid State Plan		
• Day Health Rehabilitation Services	$12/hr (FY07)	Meals, bathing, skilled nursing services, medications administration, activities, check-up, vital signs, diabetic stick, etc.
Medicaid Waiver (Choices for Care)		
• Adult Day Services	$12/hr (FY07)	Meals, bathing, skilled nursing services, medications administration, activities, check-up, vital signs, diabetic stick, etc.

Appendix 4: COVE LONG-TERM CARE WORKFORCE POLICY COMMITTEE

Peter Coutu, Executive Director, Riverside Life Enrichment Center

Michelle Champoux, BJBC Program Director, Community of Vermont Elders (COVE)

Betsy Davis, COVE President, Community of Vermont Elders (COVE)

Nancy Eldridge, Executive Director, Cathedral Square Corporation

Dolly Fleming, Executive Director, Community of Vermont Elders (COVE)

Susan Gordon, Director, Vt. Association of Professional Care Providers, (COVE)

Janet McCarthy, Director, Franklin County Home Health & Hospice

Michael Meunier, Independent Living Services Consultant, Dept. of Aging & Independent Living

Alexandra Olins, Program Manager, LEADS, Paraprofessional Healthcare Institute

Heidi Pfau, BJBC Practice Coordinator, Community of Vermont Elders (COVE)

Joan Potter, Director of Nursing, Woodridge Nursing Home

Peggy Rawlings, Direct Care Worker, Rutland Area Visiting Nurses Association & Hospice

Susan Russell, Community Services Transportation Coordinator, Central Vt. Council on Aging

Dorie Seavey, National Policy Specialist, Paraprofessional Healthcare Institute

Joan Senecal, Deputy Commissioner, Department of Aging and Independent Living

Mary Shriver, Executive Director, Vermont Health Care Association

Michael Sirotkin, COVE Lobbyist, Sirotkin & Necrason

Hollis Turnham, Michigan Policy Director, Paraprofessional Healthcare Institute

Kathy West, Project Coordinator, LEADS, Community of Vermont Elders (COVE)

ENDNOTES

[1] The term "public" refers to: Medicare-funded home health and nursing facility services, the state's Medicaid plan services, Vermont's Medicaid long-term care waivers, and state long-term care programs funded with general funds and allocations from the federal Older Americans Act.
[2] Moderate group **clinical eligibility** refers to individuals who meet any of the following clinical criteria: (1) require supervision or any physical assistance three or more times in seven days with any single ADL or IADL, or any combination of ADLs and IADLs; (2) have impaired judgment or decision-making skills that require general supervision on a daily basis; (3) require at least monthly monitoring for a chronic health condition; or (4) individuals whose health condition will worsen if services are not provided or if services are discontinued. Moderate Group **financial eligibility** refers to adjusted monthly income of the individual (and spouse, if any) such that it is less than 300% of the SSI payment standard for one person (or couple) in the community after deducting recurring monthly medical expenses (including, but not limited to, prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-payments and medical equipment and supplies). **Resource eligibility** refers to a resource standard such that all resources are less than or equal to $10,000.
[3] Hospital-based means that the nursing facility shares a wall with the hospital. Hospital-related means that the nursing facility and the hospital are affiliated, but not physically connected.
[4] Vermont Department of Aging and Independent Living (May 2006) *Shaping the Future of Long Term Care and Independent Living 2005-2015*, p. 18. Available at: http://www.dad.state.vt.us/Reports/ShapingTheFuture20052015May2006.pdf.
[5] According to a recent CMS report, "[s]ince most non-Medicaid residents required short term rehabilitation, the state determined that their higher needs were inflating case mix scores and thus overstating the cost of serving the population supported by Medicaid CMS. See Diane Justice (September 2003) *Promising Practices in Long Term Care Systems Reform: Vermont's Home and Community Based Service System*, Prepared by Medstat for Centers for Medicare and Medicaid Services, p. 10. Available at: http://www.hcbs.org/files/44/2199/VT_final.doc.
[6] State-owned or operated homes are paid retrospectively, based on allowable costs for the state fiscal year.
[7] Vermont Medicaid nursing home rates are set according to rules adopted in accordance with the VT Administrative Procedures Act (3 V.S.A. §836), *Methods, Standards and Principles for Establishing Payment Rates for Long-Term Care Facilities* (July 2005). Available at: http://www.ahs.state.vt.us/drs/NF/nhrules/nhrules.pdf.
[8] The Legislature exempted one facility from these requirements.
[9] Vermont Agency of Human Services, Division of Rate Setting. *Rate Setting Rules*, July 2005. Available at: http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/nursing-homes/nursing-home-rules.
[10] Changes in case mix scores are calculated quarterly and are part of the equation used to calculate the rate paid to each nursing facility. They are based on the amount of resources need to care for each Medicaid resident. This comes from a system called the Resource Utilization Groups (RUGs). (Medicare has its own RUG system.)
[11] The methodology for this calculation is as follows: amount of provider tax ($3,788) x number of licensed beds (3,475 on 1/1/05) = amount of tax paid; amount of tax paid ($13,162,570) divided by total number of patient days (1,134,133) = amount back in the Medicaid rate (11.61); amount back in rate (11.61) x number of Medicaid patient days (779,534) = amount paid back to nursing homes ($9,050,390) subject to 93 percent occupancy rule.
[12] The most recent *Wage Supplement Report* from the Vermont Division of Rate Setting was for the year 2003.
[13] The domains are: staff recruitment, orientation and training, staffing levels and work hours, professional development and advancement, supervisory training and practices, team approaches, and staff recognition and support.
[14] Each Gold Star Employer receives a plaque that they are encouraged to display in their lobby or reception area.
[15] Vermont Agency of Human Services, Division of Rate Setting**,** *Fact Book for 2004 and 2006.* Available at: http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/medicaid-nursing-facilities-in-vermont-fact-book/preview_popup/file.
[16] Vermont Department of Aging and Independent Living (January 2004) *Shaping the Future of Long Term Care & Independent Living 2003-2013*, p. 11. Available at: http://www.dad.state.vt.us/Reports/ShapingLongTermCare.pdf.
[17] Vermont Department of Aging and Independent Living (February 2006) *Vermont Nursing Home Occupancy Report*.
[18] Office of Vermont Health Access. This budget included Choices for Care and Global Commitment.

[19] For example, two nursing facilities, each with at least 30 longstanding empty beds, agreed to take about 40 beds/facility off-line, and in return the state provided a higher reimbursement rate for the remaining beds.
[20] The Medicaid High-Tech Program is designed to allow technology-dependent individuals, both children and adults, to live in their own homes by receiving case management and private duty nursing. The individual must depend on some type of modality, such as respiratory equipment (e.g., oxygen, ventilator), IV infusion, dialysis, or monitors for cardiac functioning, apnea, oximeter, and/or enteral feeding. In addition, the individual must require nursing care, since many of these modalities can be operated or performed by the patient or a family member without a need for nursing.
[21] Home health care services are also provided in adult day programs and in residential care homes and assisted living facilities. These service settings are treated in later sections of this report.
[22] According to the Medicare Rights Center, "Medicare will pay for home health care when the care is provided at home for homebound patients who need skilled nursing and/or skilled therapy. Whether the illness is acute, chronic or advanced, a home health agency can: Deliver skilled nursing, skilled therapy, and home health aide services in your home and supplement the care given by the family; provide practical guidance on planning for the illness, and counseling to you and your family; provide rehabilitative, maintenance or palliative care in the home. See http://www.medicarerights.org/maincontenthomehealth.html.
[23] In November 2005, CMS announced a 2.8 percent increase in Medicare payment rates to home health agencies for calendar year 2006. New MSA [Metropolitan Statistical Area] designations announced by the federal government have to be incorporated, and CMS is allowing for a one-year transition with a 50/50 blend, consisting of 50 percent of the new MSA designations' wage index and 50 percent of the previous MSA designations' wage index.
[24] The mileage rates refer to the federally mandated rates. Vermont's home health agencies are not required to pay the federal mileage rate but most do.
[25] In addition, various other for-profit and non-profit agencies provide personal care services to children covered under the State's Children's Personal Care Program.
[26] See Diane Justice (September 2003) Promising Practices reporting Long Term Care Systems Reform: Vermont's Home and Community Based Service System, Prepared by Medstat for Centers for Medicare and Medicaid Services, p. 16. Available at: http://www.hcbs.org/files/44/2199/VT_final.doc.
[27] See Children's Personal Care Services Program Guidelines, available at: http://www.dad.state.vt.us/Reports/ShapingTheFuture20052015May2006.pdf.
[28] See: http://www.dad.state.vt.us/tbi/TBI_Medicaid_Waiver_Program.htm.
[29] If companion care is paid for through the Senior Companion program, the rate is $7.52.
[30] See: http://www.dad.state.vt.us/Reports/ShapingTheFuture20052015May2006.pdf, page iii.
[31] Residential care home rules were revised in 2000 and regulations for a new licensure category of assisted living residences went into effect in March 2003. For summaries, see http://aspe.hhs.gov/daltcp/reports.
[32] "Nursing overview means a process in which a nurse assures that the health and psycho-social needs of the resident are met. The process includes: observation, assessment, goal setting, education of staff, and the development, implementation, and evaluation of a written individualized treatment plan to main the resident's well being." From http://aspe.hhs.gov/daltcp/reports/04alcomVT.pdf, p. 3-342.
[33] Robert Mollica and Heather Johnson-Lamarche (March 2005) *State Residential Care and Assisted Living Policy: 2004*. Prepared for Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Available at: http://aspe.hhs.gov/daltcp/reports/04alcom3b.pdf.
[34] Robert Mollica and Heather Johnson-Lamarche (March 2005) *State Residential Care and Assisted Living Policy: 2004. Prepared for Office of Disability*, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Available at: http://aspe.hhs.gov/daltcp/reports/04alcom3b.pdf.
[35] Some of the additional requirements for ALRs include: 1) ALRs must provide a resident unit of at least 225 square feet that includes private bedroom and bathroom, kitchen capacity and lockable door (vs. RCH, 100 sq feet/ private room or 160 per shared room; no requirements for resident room kitchen capacity or lockable door); 2) ALRs must initiate a service negotiation process, commonly known as the negotiated risk process, whenever the licensee determines that a resident's decision, behavior or action places the resident or others at risk of harm. The mutually-agreed upon plan must be in writing, dated and signed by both parties and incorporated into the resident's care and service plan; and 3) in addition to the admission agreement, ALRs complete a uniform consumer disclosure

statement that states the services the ALR will provide and describes all service packages tiers and rates (the statement is to be provided to residents prior to or at admission and to the public upon request, and it must be included in all marketing brochures and written materials).
[36] Vermont Department of Aging and Independent Living, *Shaping the Future of Long Term Care and Independent Living*, Table 4. Available at: http://www.dad.state.vt.us/Reports/ShapingTheFuture20052015May2006.pdf.
[37] See report available: http://www.dad.state.vt.us/Reports/DementiaCare.htm.
[38] DAIL last updated the *Standards for Adult Day Services in Vermont* on March 11, 2004.
[39] One unit = one hour.
[40] Data from: Vermont Department of Disabilities, Aging, and Independent Living, Division of Disability and Aging Services, Community Development Unit.
[41] Vermont Department of Aging and Independent Living (May 2006), *Shaping the Future of Long Term Care and Independent Living,* Table 4. Available at: http://www.dad.state.vt.us/Reports/ShapingTheFuture20052015May2006.pdf.
[42] DHRS recently was transferred to the new Global Commitment Waiver.
[43] Specific services can include: breakfast, full lunch, dinner (if appropriate), afternoon snack, shower, exercises, vitals, skilled nursing, medication administration, diabetic stick, social work. Transportation services are not included in the rate.
[44] BJBC (Summer 2004) "Vermont Consumer Advocates Align the Stars for Direct Care Worker Advances," Insights, No. 4. Available at: http://www.bjbc.org/page.asp?pgID=126.
[45] For an analysis of state Medicaid rate-setting methods for home- and community-based services, see Dorie Seavey and Vera Salter (October 2006) *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants,* Washington, DC: AARP Public Policy Institute. Available at http://assets.aarp.org/rgcenter/il/2006_18_care.pdf.
[46] Center for Health Program Development and Management (April 2006) *Community-Based Long-Term Care Services in Rhode Island: A Report Issued Pursuant to Joint Resolution 05-R 384 (2005*). Prepared for the RI Department of Human Services, Baltimore County: CHPDM, University of Maryland.
[47] These components are developed further in: Dorie Seavey and Vera Salter (October 2006) *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants,* Washington, DC: AARP Public Policy Institute. Available at http://assets.aarp.org/rgcenter/il/2006_18_care.pdf.