

# Long-Term Care System Sustainability Study



## Summary of the Current System & Recommendations for Sustainability

*Submitted By:*  
**THE DEPARTMENT  
OF  
DISABILITIES, AGING AND INDEPENDENT LIVING**

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## I. EXECUTIVE SUMMARY

Vermont's policy of helping elders and adults with disabilities to live with dignity and independence in settings of their choice has been in place for more than 30 years. During those years, there have been dramatic shifts in demographics, consumer preferences, state and federal law, availability and flexibility of federal dollars and the proportion of the state's Medicaid expenditures for long-term care. The balance continues to shift to increased use of home and community-based care and less reliance on institutional care. These changes have placed increasing pressures on all sectors of Vermont's long-term care system. The Legislature's mandate to create a plan for the sustainability of the long-term care system was an effort to address concerns about the capacity and ability of the system to meet consumer needs and demands over the next ten years.

In 2006, the Vermont Legislature amended H.881, Sec. 149 to include the following charge to the Department of Disabilities, Aging, and Independent Living (DAIL):

*It is the intent of the general assembly that the department of disabilities, aging, and independent living collaborate with nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers to develop a long-range plan to address the sustainability of the Vermont's long-term care system.*

The legislation also called for recommendations on: the future of nursing facilities; the development of adequate home and community based services to support increased numbers of Vermonters receiving that type of care; and the use of indexing as an appropriate method of ensuring sustainable funding for home and community based services.

This report identifies how key services will expand or be sustained and discusses some new services under development. It describes the status and challenges of the numerous programs, services, and providers that provide care and supports to Vermont's elders and adults with physical disabilities. It lays out a 10-year vision for the long-term care system. The report examines the capacity of nursing facilities and the home and community-based service sector to meet projected needs. The Task Force recommends creating a mechanism for systematic reimbursement for components of the home and community based long-term care system, and makes additional recommendations concerning nursing facilities and the direct care workforce. Finally, the report describes two possible mechanisms for bringing additional private funds to pay for long-term care services.

The Legislature asked the Task Force to forecast the number of nursing facility beds to meet the projected need over the next 10 years reported by region. Appendix D depicts that scenario by county, utilizing Vermont's 2005 ratio of licensed nursing facility beds per one hundred people with disabilities age 18+ and applying the 2005 ratio to 2015. Were Vermont to have the same ratio of beds to people in 2015 as it did in 2005, there would be 369 fewer nursing facility beds.

The Task Force also wanted to project the capacity needed for a more balanced long term care system in eight major home and community based components over the next 10 years.

Included in that forecast are: personal care under the Choices for Care waiver; adult day services; enhanced residential care; attendant care (ASP); homemaker services; assistive community care services (ACCS); assisted living residence capacity; and private pay residential care capacity.

The Task Force adopted a methodology created by DAIL based on the concept of a statewide projected service use rate for 2015. The 2015 Projected Use Rate was derived by taking the 2015 projected use (i.e. number of participants) and dividing it by the 2015 projected number of non-institutionalized people with disabilities,<sup>1</sup> 18 years of age or older in Vermont.<sup>2</sup> Using this approach, a 2015 Projected Use Rate state average was calculated for each of the eight services/programs and then applied to each county.

According to the forecast, all counties would need to increase their capacity, some more dramatically than others. Many home and community based providers reported that the current reimbursement rates make it difficult to meet the current needs and that expanding services would be very challenging.

At present, nursing facilities are the only sector of Vermont's long-term care system for which there is a structured reimbursement system, including an annual inflationary adjustment. There is no similar system for home and community based providers. Absent any systematic reimbursement system, providers often wait years for rate increases, affecting their ability to provide services, retain staff and expand their services and programs to meet the increasing demands. The study finds that applying systematic rate increases to current inadequate base rates in future years may not achieve the desired outcome of sustainability for some providers.

After discussing the pros and cons of creating a cost-based reimbursement system for each home and community-based provider group and considering several indexes for potential use, the Task Force concluded that it lacked the time, resources, and technical expertise to conduct a thorough study and reach a conclusion about the merits and feasibility of this approach. The Task Force concluded that the prudent approach for the present is to use a straight percentage increase. The Task Force and the Department make separate recommendations about which services should receive the inflationary increase.

The Task Force identified the following pertinent issues:

- Some government reimbursement rates are not sufficient to cover the costs of delivering services, which presents a major challenge for LTC providers.
- There is additional need for residential care, assisted living, adult day services, case management and other home and community-based services; however, expansion at the time when many programs and services are financially vulnerable presents additional challenges.
- Strategic thinking and planning are required to right-size the nursing facility industry.
- There is no equitable method for allocating resources proportionately among services for elders and younger adults with disabilities.

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<sup>1</sup> Disability in this context is defined as needing assistance with 2 or more activities of daily living (ADLs).

<sup>2</sup> Includes all populations and payers.

- Employment compensation, benefits, and wage disparities across the long-term care system create difficulties in the hiring and retention of employees.
- Increased liability insurance premiums are an issue for some providers.
- Many parts of the home and community-based service sector feel pressured to do local fundraising, resulting in "contribution fatigue," saturation, and dilution of those efforts in communities.

The study concludes with 12 recommendations. The Department of Disabilities, Aging and Independent Living and the Long-Term Care Sustainability Task Force reached agreement on some, but not all, of the recommendations. In the table below, the column on the left represents recommendations about which the Department and the Task Force have reached agreement. The column on the right represents areas where the Task Force differs from or augments the Department's recommendation.

**Recommendations of the Long-Term Care System Sustainability Study**

<b>DAIL/Task Force Recommendations</b>	<b>Additional Task Force Recommendations (areas where agreement with DAIL have not been achieved or language augments the DAIL recommendation)</b>
<p>1. The rates for all providers of long-term care services in the Choices for Care 1115 demonstration waiver should be adjusted by an annual inflationary factor. This would include people participating in the consumer- and surrogate-directed options. Nursing facilities are currently the only Choices for Care provider for whom there are statutory inflationary increases. For SFY08, the recommended inflationary factor is 3.75%; an increase of \$613,745 in state funds. The Choices for Care case management rate, which is already \$65/hour, would not be increased.</p>	<p>1 a. The Task Force recommends that rates for all providers of long-term care services and supportive services should be adjusted by an annual inflationary factor. This includes but is not limited to services covered by Choices for Care (personal care, Enhanced Residential Care, adult day services, respite and companion services), Assistive Community Care Services (ACCS), Medicaid-funded adult day services, Attendant Services Program, homemaker services, some AAA services, some VCIL services, TBI waiver, Dementia grants, Eldercare Clinician program, and LTC Ombudsman. Nursing facilities were not included in this list because they already receive a statutorily required annual inflationary increase.</p> <p>The Task Force recommends an inflationary increase of 4% for FY08. The results of an across-the-board 4% increase to home and community-based providers are shown in Appendix E. This amounts to an increase of \$1,147,993 in state funds.</p> <p>The Task Force also recommends that further study must be done to arrive at an equitable reimbursement system for the future. Because an in-depth study will take time, the Legislature should not wait for that system to be developed, but should increase current rates now so current problems are not exacerbated.</p>

<p>2. Review and increase funding to certain home and community-based providers. Because some providers of home and community-based services have not received increases for several years, initiating annual inflationary increases in SFY08 will continue to leave some home and community-based providers in a vulnerable position.</p>	<p>2 a. The Task Force believes that annual inflationary increases, when applied to current, inadequate base rates, may not achieve the desired outcome of sustainability for the long-term system. It is imperative that adequate funds be invested to meet the growing need for home and community-based services and to increase base rates for underpaid service sectors. The Task Force strongly supports the intent of Act 56, which requires that “Any savings realized due to the implementation of the long-term care Medicaid 1115 waiver shall be retained by the department and reinvested into providing home- and community-based services under the waiver.”</p>
	<p>3 a. DAIL should develop a method for equitably allocating resources to serve both elders and adults with disabilities, based on the relative number of people to be served in each population.</p>
	<p>4 a. The relative acuity of persons receiving LTC services should be considered in efforts to achieve equitable reimbursements across components of the LTC system, so that the complexity of care delivered is reflected in the reimbursement rate.</p>

<p>5. Continue to find ways to right-size the nursing facility industry with the goal of maintaining (1) an adequate number of resident beds to meet the need the next 10 years and (2) nursing facilities as a quality LTC option. Efforts will include:</p> <ul style="list-style-type: none"> <li>• Supporting quality improvement and culture change initiatives as described in the report from the Nursing Facilities for the 21st Century Task Force.</li> <li>• Helping interested nursing facilities to right-size their facilities, including pursuing the concept of contracting for Medicaid resident bed days as one potential method.</li> </ul>	
<p>6. Strengthen, support, and invest in the development of housing with supportive services, through the construction of additional housing units and by bringing supportive services to current housing sites and naturally occurring retirement communities. Work with the public, non-profit and private housing industries and other appropriate parties to design a 10-year plan that will achieve this objective.</p>	
<p>7. Continue the efforts to ensure an adequate supply of well-trained and supported direct care workers by promoting culture change, supporting training, the development of a state-wide caregiver registry and publicly recognizing the importance and value of this career choice. The Direct Care Workforce Task Force will provide recommendations for accomplishing these goals in its final report in December 2007. (See page 49 for their interim recommendation.)</p>	

<p>8. Strengthen access to quality mental health services for elders and adults with disabilities by:</p> <ul style="list-style-type: none"> <li>• Increasing funding for the Eldercare Clinician Program.</li> <li>• Creating the expertise in DAIL, in collaboration with the Department of Health, Division of Mental Health, to offer support to nursing facilities and community-based providers to appropriately address the mental health issues of the people they serve.</li> </ul>	<p>8 A. Systems development and ongoing support of quality mental health services must be adequately funded in order to address widespread gaps in these services for elders and adults with disabilities.</p>
<p>9. Continue to strengthen consumers' access to complete and unbiased information about LTC services by seeking on-going funding to support the development and ongoing operation of Aging and Disability Resource Collaboratives (ADRCs).</p>	<p>9 A. Information/Referral/Assistance (I/R/A) systems and system development for elders and adults with disabilities must be adequately funded. ADRCs are one model for providing I/R/A, but until the effectiveness of the Vermont pilot projects are evaluated, it is premature to allocate state funds to support their development and ongoing operation.</p>
<p>11. Research the costs, benefits, and risks to the state and to consumers of various methods that have the potential for bringing non-Medicaid revenues to meet Vermonters' long-term care needs, such as reverse mortgages and long-term care insurance.</p>	
<p>12. An extended study of the sustainability of the LTC system is needed. The work started by this Task Force should continue, with adequate time, funding, and expert technical assistance provided to accomplish its work. An extended study should include research on financial incentives and financing mechanisms that can assist the development of infrastructure to support home and community-based services.</p>	

In addition to its own recommendations, the report offers specific recommendations from three concurrent, related reports: *The Nursing Facilities for the 21<sup>st</sup> Century Study*, *The Nursing Facility Reimbursement Study*, and *The Direct Care Workforce Study Interim Report*.

## II. PURPOSE OF THIS STUDY

Vermont's policy of helping elders and adults with disabilities to live with dignity and independence in settings of their choice has been in place for more than 30 years. The intervening years have seen dramatic shifts in demographics, consumer preferences, state law, availability and flexibility of federal dollars, and the proportion of the state's Medicaid budget that is spent on long-term care. The balance continues to shift to use of more home and community-based care and less reliance on institutional care. These changes have placed increasing pressures on all sectors of Vermont's long-term care system. The Legislature mandated the creation of a plan for the sustainability of the long-term care system in an effort to address their concerns about the capacity and ability of the system to meet changing consumer needs and demands.

In 2006, the Vermont Legislature amended H.881, Sec. 149<sup>3</sup> to include the following charge to the Department of Disabilities, Aging, and Independent Living (DAIL):

*It is the intent of the general assembly that the department of disabilities, aging, and independent living collaborate with nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers to develop a long-range plan to address the sustainability of the Vermont's long-term care system.*

The legislation also called for the creation of a task force to assist DAIL's Commissioner to develop recommendations on: the future of nursing facilities; the development of adequate home and community-based services to support increased numbers of Vermonters receiving that type of care; and the use of indexing as an appropriate method of ensuring sustainable funding for home and community-based services.

This report identifies how key services will expand or be sustained and discusses some new services under development. Certain key providers such as nursing facilities, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day services will continue to be integral in every community; however, these providers will undoubtedly continue to change and evolve as they have over the past ten years as consumer preferences change. Over the next five to ten years, these providers will need to be ready to adapt to the changing market. The state will be challenged to manage this change to ensure the right proportion and distribution of key services as the market evolves.

While it is likely that all of the provider types that exist today will play some role in providing care and supports to elders and people with disabilities over the course of the next 10 years, it is not the intent of this study to support or sustain specific types of providers or to maintain the status quo. The system must be flexible enough to respond as consumer preferences change and new options are created.

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<sup>3</sup> Section 149 addresses Nursing Facilities and the Home and Community-based System

This report describes the features and status of the numerous programs, services, and providers that provide care and support to Vermont's elders and adults with disabilities. It lays out a vision for the long-term care system for the next 10 years. The report examines the capacity of nursing facilities and the home and community based service sector to meet projected needs. It describes two possible mechanisms for bringing additional non-Medicaid funds to pay for long-term care services. The report concludes with observations and recommendations from DAIL and the Task Force and includes additional recommendations concerning nursing facilities and the direct care workforce.

### **III. PROCESS USED TO DEVELOP THIS REPORT**

In response to the charge from the Legislature, the Commissioner of the Department of Disabilities, Aging, and Independent Living convened a Long-Term Care Sustainability Task Force to assist DAIL in studying the issues and developing recommendations regarding the sustainability of Vermont's long-term care system. Task Force membership included more than 20 agencies and organizations that represented constituencies including elders, adults with disabilities, nursing facilities, residential care facilities, adult day programs, housing providers, home health agencies, area agencies on aging, faith-based organizations, the Long-term Care Ombudsman program, the Vermont Center for Independent Living, and the Community of Vermont Elders, the Vermont Coalition for Disability Rights, as well as members of the DAIL Advisory Board. One member of the Senate and two members of the House of Representatives participated on the Task Force. Participants also included staff from the Office of Vermont Health Access, the Joint Fiscal Office, and Legislative Council. (See Appendix H for a full list of Task Force attendees.) The Deputy Commissioner of DAIL chaired the Task Force, which met eight times between June 2006 and January 2007. All meetings were open to the public and DAIL welcomed new participants at each meeting.

DAIL has convened three other task forces to undertake additional studies related to the sustainability of the long-term care (LTC) system. Two of those studies are specific to the sustainability of nursing facilities. A report entitled *Nursing Facilities for the 21<sup>st</sup> Century* describes the findings and recommendations from the task force that addressed the issues of potential new revenue sources for nursing facilities, right-sizing the industry, and helping nursing facilities to become more consumer-responsive and accessible for the benefit of residents and visitors.<sup>4</sup> A second task force studied issues related to nursing facility Medicaid reimbursement.<sup>5</sup> The reports developed by those task forces have informed the work of the Long-Term Care Sustainability Task Force and were used as resources for this over-arching study of the sustainability of Vermont's long-term care system. A third task force is currently conducting a study of Vermont's direct care workforce, another critical component of the system. That report is due December 31, 2007; however an interim report will be presented to the Legislature in January 2007.

Several additional reports, along with data provided by DAIL and other sources, also informed the work of this Task Force. Those resources are identified in Appendix G.

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<sup>4</sup> *Nursing Facilities for the 21<sup>st</sup> Century*. DAIL, January 2007. [www.dail.state.vt.us](http://www.dail.state.vt.us)

<sup>5</sup> *Nursing Facility Reimbursement Study*. DAIL, January 2007. [www.dail.state.vt.us](http://www.dail.state.vt.us)

Of particular note is the landmark study *Reimbursement Practices and Issues in Vermont's Long-Term Care Programs*, which was published by the Community of Vermont Elders (COVE) and upon which this report has drawn extensively.<sup>6</sup> That document provides detailed descriptions of several important components of the long-term care system along with data on rates, numbers of persons served, when rates were last updated and the method, if any, of determining rates.

#### IV. CONTEXT FOR THE LONG-TERM CARE SUSTAINABILITY STUDY

Since the passage of Act 160 in 1996, substantial progress has been made in pursuit of Vermont's policy of helping elders and adults with disabilities to live with dignity and independence in settings of their choice. Act 160 required the State to take dollars saved from reduced Medicaid nursing facility utilization and reinvest those funds in home and community-based care. Since the passage of Act 160, the proportion of public long-term care dollars spent on home and community-based services has grown from 12% to 32%.

Vermont's aging population and the increasing number of adults with disabilities will continue to generate increased demands on the long-term care system. The number of elders age 65 and over is projected to more than double during the period 1990-2020. While the prevalence of disability is rising among the younger population, it is decreasing for elders, many of whom will remain healthy and live free of disability for longer periods of time. In spite of this, the actual number of older people with disabilities will increase because of population growth. Declining disability rates in the older population and Vermont's aggressive efforts to improve and expand home and community-based services have led to a significant decrease in the use of nursing facility care. This decline is expected to continue throughout the next 10 years, while the number of people with significant disabilities living in the community is projected to grow by 36% over the same period.<sup>7</sup>

In 2002, the Vermont Legislature created the Vermont Olmstead Commission in response to the 1999 U.S. Supreme Court Olmstead ruling that found that the Americans with Disabilities Act (ADA) requires states to provide community based service for persons with disabilities.<sup>8</sup> The Olmstead Commission was charged with creating a plan "for placing qualified people with disabilities in the most integrated settings so that Vermonters with disabilities are not unjustifiably isolated and denied the opportunity to live with respect and dignity in the community."<sup>9</sup> The Vermont Olmstead Plan identifies existing capacities, gaps, and financial implications of carrying out this mandate.<sup>10</sup>

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<sup>6</sup> *Reimbursement Practices and Issues in Vermont's Long Term-Care Programs*. Prepared by the Paraprofessional Healthcare Institute for the Community of Vermont Elders (COVE). November 2006.

<sup>7</sup> *Shaping the Future of Long-term Care and Independent Living 2005-2015*. DAIL, May 2006. <http://www.dail.state.vt.us>. Disability is defined as needing assistance with 2 or more Activities of Daily Living (ADLs).

<sup>8</sup> *Olmstead v LC*, No 98-536 (US Sup Ct, June 22, 1999)

<sup>9</sup> Act 135 of the 2002 Vermont General Assembly

<sup>10</sup> *Vermont Olmstead Plan*. Vermont Olmstead Commission, January 3, 2006.

<http://humanservices.vermont.gov/publications/olmstead-commission/vermont-olmstead-commission-comprehensive-plan/view>

The State continues to work to reduce reliance on an institutional model for long-term care and to increase support for home and community-based options. The goal of this "rebalancing" effort is the achievement of a 60/40 balance (i.e., 60 Medicaid-funded nursing facility residents for every 40 Medicaid-funded home and community-based participants) in the near term, and a 50/50 balance in the future. To further that goal, Vermont implemented "Choices for Care in 2005," a first-in-the-nation federal 1115 Medicaid Long-term Care Waiver that provides an entitlement to home and community-based services. The flexibility of the Choices for Care Waiver creates increased opportunities for expansion of the home and community based system. These rebalancing goals can be met only if the appropriate mix of services and supports can be identified, achieved, and sustained.

## V. VISION FOR VERMONT'S LONG-TERM CARE SYSTEM<sup>11</sup>

As we look five to ten years into the future, we envision a system in which:

- Vermonters have more control over their long-term care services and support. They are empowered to make decisions and more options are available to them.
- Services continue to be locally based, so Vermonters will not have to travel far from home to get the services they prefer or need.
- More people are receiving the services they need in their own homes, rather than in nursing facilities.
- There are fewer institutional settings; however the remaining nursing facilities are financially stronger and provide residents with a more home-like setting.
- Consumers have access to a greater variety and quantity of residential options, so if they want to continue to live in their own homes, they have options to do so.
- Complete, accurate and unbiased information about long-term care services and supports is available and easy to access.
- Long-term care services are coordinated and integrated with acute and primary care so Vermonters experience flexible, consumer-centered and cost-efficient services.
- Services such as adult day and a variety of respite options are available to support unpaid caregivers.
- Services are coordinated with other activities, such as employment, to help those who want to participate in and contribute to their community in a variety of ways.
- As home and community based services expand to meet consumer demand, the system as a whole remains financially sustainable.

All components of the system will operate based on the following core principles:

- *Person-centered* – the individual will be at the core of all plans and services.
- *Respect* – Individuals, families, providers and staff will be treated with respect.
- *Independence* – The individual's personal and economic independence will be promoted.
- *Choice* – Individuals will have options for services and supports.
- *Self – Determination* – Individuals will direct their own lives.

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<sup>11</sup> The LTC Sustainability Task Force adopted DAIL's vision statement and core principles.

- *Living Well* – The individual’s services and supports will promote health and well-being.
- *Contributing to the Community* – Individuals are able to work, volunteer, and participate in local communities.
- *Flexibility* – Individual needs will guide our actions.
- *Effective and Efficient* – People’s needs will be met in a timely and cost effective way.
- *Collaboration* – Individuals will benefit from our partnerships with families, communities, providers and other federal, state and local organizations.

## VI. COMPONENTS OF VERMONT’S LONG-TERM CARE SYSTEM

The Task Force spent a considerable amount of time discussing the components of the system that should be included in this study. The complexity of the system demanded an in-depth discussion of which providers, services and programs should be included and which should not. The Task Force concluded that “Core” long-term care programs, services and providers should be distinguished from a second tier of services, programs and providers that support elders and people with disabilities.

For purposes of this study, the “**Core**” components include the range of settings where people receive care and support:

- Nursing facilities
- Residential care homes
- Assisted living residences
- Adult day centers
- Individuals’ homes (including apartments in congregate housing).

The following providers and programs are included in the Core area:

- Home health agencies
- Area agencies on aging (AAAs)
- Vermont Center for Independent Living (VCIL)
- Independent care providers hired directly by participants (including non-licensed home providers)
- Housing-based services
- Attendant Services Program (ASP)
- Eldercare Clinician Program
- Traumatic brain injury (TBI) providers
- Program for All-Inclusive Care for the Elderly (PACE), start up in 2007
- Informal care providers (friends and family)
- Respite services.

**Additional essential services, programs and providers that support elders and adults with disabilities** include:

- “Bricks and mortar” housing production
- Transportation
- Community based volunteer programs (e.g. Neighbor to Neighbor, Senior Companions, faith-based initiatives)

- Services for persons who are blind or visually impaired and services for persons who are Deaf, hard of hearing or late-deafened
- Health promotion services
- Benefits counseling.

The Developmental Disabilities Services system (also part of the long-term care and support system under the Department of Disabilities, Aging and Independent Living) was not included in this study because another task force has undertaken a review of the sustainability of the mental health and developmental services provider system, i.e. the Designated Agencies and Specialized Services Agencies.

### **CORE LONG-TERM CARE PROGRAMS, SERVICES, AND PROVIDERS**

Each provider group was asked to provide the Task Force with an overview of their current status and challenges for the future of their organizations. The information that follows is based, in whole or in part, on their presentations to the Task Force. Statements made by LTC providers are duly noted.

### **NURSING FACILITIES**

Since the passage of the Act 160 “Shifting the Balance” legislation in 1996, the long-term care system has been undergoing gradual changes in response to Vermonters' requests for home and community based options in addition to nursing facility care. In October 2005, Vermont started a demonstration waiver called Choices for Care. This waiver removes the long-standing bias toward institutional care that existed in the Medicaid program. Prior to this waiver, individuals who preferred to receive their long-term care services in the community, rather than in a nursing facility, had to wait until a “slot” opened in the former home and community based waiver program. Enrollees in this new waiver have the ability to choose the setting in which they receive their care and support, provided they meet both the financial requirements and clinical criteria for long-term care.

As the home and community based parts of the system continue to grow, more options have become available for Vermonters. Staying at home longer means that when people do enter a nursing facility, they are generally in need of more care. In addition, shorter hospital stays have enabled nursing facilities to increase their capacity to provide post-acute rehabilitation services. Over time, nursing facilities have continued to increase their capacity to provide post-acute rehabilitation services. Many Level III Residential Care homes participate as Enhanced Residential Care providers and provide care to residents who meet the “Nursing Home Level of Care” criteria. Adult day centers provide care for many people who also meet that level of care criteria.

These changes are having an impact on nursing facilities. As of October 1, 2006, there were 419 fewer licensed beds than in 1996. Some nursing facilities are experiencing significant

financial pressure. Five facilities are receiving extraordinary financial relief from the State, two have filed requests and one facility is in the process of closing.<sup>12</sup>

Other facilities have received a qualified opinion on their audited financial statements. This type of qualification is called a “going concern” qualification.<sup>13</sup> Three nursing facilities receive enhanced rates as a result of legislative action. According to the Vermont Health Care Association (VHCA), the total loss shown on 2005 profit and loss statements for 27 of the 40 facilities totaled \$10,987,345. Nursing facilities across the country are looking for ways to respond to the changing market and Vermont is no exception.

The nursing facility industry in Vermont is not homogeneous. The following description provides some details about the facilities operating in Vermont. (See Appendix A for a Glossary of terms.)

Vermont has a total of 43 nursing facilities. Three of these facilities do not accept Medicaid residents.

- Facilities range in size from 12 resident beds to 184 resident beds.
- As of October 1, 2006 Vermont had 3,425 licensed beds<sup>14</sup>.
- Forty (40) facilities are dually certified to accept Medicare and Medicaid payments.
- Medicare/Medicaid dually licensed beds numbered 3,196 as of October 1, 2006.
- 199 beds are certified for non-Medicare use only (26 are for private pay residents only).

Nursing facilities fall into eight different ownership categories: (See Appendix F for details by facility.)

- Owned by out-of-state “chains” (16)
- Vermont-based ownership groups (5)
- Hospital-based (these non-profit facilities share a common wall with a hospital) (2)
- Hospital-related (non-profit facilities under the hospital “umbrella,” but not physically connected to the hospital) (4)
- Not-for-profit facilities (6)
- For-profit independent facilities (6)
- State-owned facility – Vermont Veterans Home (1)
- Non-Medicaid facilities (3).

The Vermont Veterans Home is unique, since it is the only state-owned nursing facility. DAIL is reviewing various options and opportunities as they relate to the Veterans Home. More details about this facility are found in the *Nursing Facilities for the 21<sup>st</sup> Century Report*.

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<sup>12</sup> On January 2, 2007, Morrisville Center Nursing Home announced plans to close the facility.

<sup>13</sup> This qualification alerts all users of the financial statement that this facility may not be able to continue in its accustomed business in the future.

<sup>14</sup> Includes the private pay and Medicare-only facilities, downsizing of Burlington Health and Rehab by 42 beds, and a 10-bed increase at Menig Extended Care in Randolph.

In the last five years, the supply of nursing facility resident beds decreased by 6%.<sup>15</sup> Increasingly, residents come for short rehabilitation stays after hip, knee, and other surgeries. According to VHCA, many facilities currently discharge more residents in one month than they used to discharge in one year. The average occupancy rate in 2006 was 91%.

According to VHCA, the gap between the actual cost of providing care and Medicaid reimbursement rates is substantial. VHCA also stated that the average loss/day statewide for Medicaid residents is \$22.83.<sup>16</sup> Twenty-seven (27) facilities had substantial losses in 2006, as compared to 31 in 2005. To cope with these losses, competition for Medicare residents is high. The total loss for all nursing facilities in 2006 was close to \$11 million (this is not limited to Medicaid residents). VHCA also told the Task Force that facilities with high Medicaid utilization have the greatest Medicaid losses and must rely on cost shifting to other payment sources to cover those losses. With higher costs and declining census, some nursing facilities are in crisis.

AHS contends that the nursing facility reimbursement system is designed to fairly reimburse facilities for the care provided to Medicaid-funded residents using limited cost-containment mechanisms, e.g. caps on certain cost centers.

As more consumers choose home and community based long-term care options, nursing facilities are looking at new markets for their services. They will continue to build their markets with Medicare, private pay and private insurance coverage. In addition, a need for specialized services has been identified, e.g. additional capacity for dementia care, care for geriatric residents with challenging behavioral health needs, care for residents with degenerative neurological disorders such as Huntington's Chorea, persons with Traumatic Brain Injuries (TBI) for whom community placements can not be found, and ventilator-dependent residents.

VHCA identified additional challenges:

- The trend is toward sicker residents with more complex needs, including those with extreme behavior problems and residents who are ventilator-dependent.
- Buildings are old and built on a hospital model. Most facilities were built in the 1960's and two facilities were built in the 1890's. The demand for more home-like settings is growing, including the desire for private rooms with private baths.
- Some facilities have substantial loans. Smaller Vermont-owned facilities cannot continue to operate under these circumstances and corporate-owned facilities are also making decisions about continued operations in Vermont, based on the overall financial health of the corporation.
- Consumer demand for facilities that offer more home-like settings will take a significant investment in new construction and bridge funding to enable facilities to maintain their current structures while they build for the future.

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<sup>15</sup> As of October 1, 2006.

<sup>16</sup> Presentation to the LTC Sustainability Task Force by Mary Shriver, Vermont Health Care Association, July 13, 2006.

## HOME AND COMMUNITY BASED PROGRAMS, SERVICES, AND PROVIDERS

### 1. RESIDENTIAL CARE HOMES

Residential care homes (RCHs) are licensed by the State to provide room and board and some supervision and personal care for residents who may need limited help with some aspects of daily living. Level III RCHs generally serve individuals who are unable to live independently but do not require the level of care provided by nursing facilities. There are currently 102 Level III RCHs with a capacity of 2,180 beds. Average statewide occupancy is eighty-three percent (83%).<sup>17</sup> Eighty-four percent (84%) of RCHs accept payment for Medicaid-covered services from Vermont's Assistive Community Care Services program (ACCS), which includes case management, assistance with activities of daily living, and nursing oversight. Additional revenue comes from private pay residents. Medicare does not cover RCH care.

Fifty-seven (57) of the RCHs are also approved to provide Enhanced Residential Care (ERC) through the Choices for Care Waiver. ERC provides a higher level of care to individuals who qualify for nursing facility admission but opt to reside in non-institutional, home-like settings. The current ERC capacity is 353 beds (November 2006 data). ERC reimbursement has three payment tiers, based on the level of care needed by the individual. (See the COVE *Reimbursement Practices* report for specific information about rates.)

The current low RCH reimbursement rates make it difficult for many RCHs to provide competitive wages and benefits to staff and to make needed capital improvements, including safety upgrades. Additional financial pressure on RCHs has resulted from dramatic increases in the number of residents with dementia who require more services, more complex care, and greater supervision. According to residential care home providers, an additional \$1,226,695 in state funds would be needed in SFY08 to raise the ACCS rate to \$44.56/day, which that provider group states is an appropriate reimbursement level. (The current rate is \$33.25/day.) During SFY05, 1,068 people used ACCS as their payment source.

The Vermont Health Care Association provided the Task Force with the following description of the status of Vermont's residential care homes:<sup>18</sup>

- Larger residential care homes are generally in good financial condition and are even doing some new construction. Niche markets can support growth.
- While some of the non-profit RCHs are in stable financial condition, others operate on the edge.
- The financial health of privately-owned RCHs is also mixed. A significant number of small, privately owned RCHs are operated by a single individual. This group of RCH providers needs assistance and community involvement to build reserves, develop business plans, and plan for alternative management should the owner decide to sell or no longer be able to continue in business.

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<sup>17</sup> SFY06 Residential Home Care Survey. DAIL.

<sup>18</sup> Presentation to the LTC Sustainability Task Force by Nancy Bourne, Vermont Health Care Association, July 13, 2006.

DAIL projects 26% growth in the number of ACCS participants from 713 at any given point in 2005 to 900 in 2010, and 36% growth in the number of ERC participants from 182 at any given point in 2005 to 247 in 2010.<sup>19</sup> As noted in the COVE *Reimbursement Practices* report, "The fundamental logic and success of the new Choices for Care Waiver depends on the continued vitality of RCHs and ALRs (Assisted Living Residences) 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."<sup>20</sup>

## 2. ASSISTED LIVING RESIDENCES

Assisted Living Residences (ALRs) are a fairly recent addition to the array of residential options in Vermont, with the first ALR opening in 2003. ALRs were developed to promote the goal of "aging in place," a term used to describe the benefits of assisting elders and persons with disabilities to remain in one setting rather than moving from setting to setting as their care needs increase. The ALR philosophy is to provide a private, apartment-style home setting and promote independent living. ALRs can be viewed as housing with personal care services. Services include meals, 24-hour nursing oversight, medication management, laundry, housekeeping, and activities. Because ALRs promote aging in place, they are required to retain residents as their care needs increase and provide needed care, within specified limits. The regulations place limitations on admissions related to the amount and type of care needed, i.e., prospective residents may not have a serious acute illness that requires hospital-level care, nor may they require ventilator or respirator care, or two-person transfers).

There are six (6) ALRs in Vermont<sup>21</sup>, three (3) of which accept Medicaid Assistive Community Care Services (ACCS) Medicaid payments. There are 21 approved Enhanced Residential Care beds in the ALRs that accept Medicaid, although only a small percentage of those beds are utilized for ERC participants. The ALRs have a total of 249 units, with a maximum occupancy of 293.

ALR rates cover rent, utilities, meals, services, personal care, and nursing. Revenue comes from resident payments, payment for meals, HUD and Rural Development housing subsidies, Medicaid Assistive Community Care Services (ACCS) payments, and Enhanced Residential Care (ERC) Choices for Care Waiver payments.

Payment by residents who have Medicaid coverage is capped to ensure that they do not fall below the Medicaid Protected Income Level. According to testimony provided to the Task Force by the spokesperson for the ALRs, the maximum revenue obtained from the residents, housing subsidies, and Medicaid does not cover the cost of providing services.

ALRs are quite distinct from residential care homes and in a separate licensing category, but the general public does not understand the distinction. According to the ALR spokesperson,

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<sup>19</sup> *Shaping the Future 2005-2015*, op cit.

<sup>20</sup> *Reimbursement Practices and Issues in Vermont's Long Term-Care Programs*, op cit.

<sup>21</sup> Assisted Living Residences are located in Burlington, Rutland, Norwich, Vernon, Windsor, and Woodstock.

that confusion is a major barrier to the development of assisted living.<sup>22</sup> Consumers have mixed expectations and funders do not understand the model. ALRs differ from Level III Residential Care Homes in their philosophy, use of negotiated risk procedures, required discharge restrictions, requirements for a uniform consumer disclosure document and apartment-style housing.

ALRs reported the following challenges to their future viability:

- In contrast to nursing facilities, they may not bill for days when the resident is out of the ALR (also known as “Out of House” stays). Nursing facilities may bill Medicaid to hold the bed for a resident for up to 10 days for short hospital stays or visits with family if the facility is not fully occupied.
- Premiums for liability insurance, workers compensation, and directors' and officers' coverage have all increased.
- Low Medicaid rates mean that costs are shifted to private pay residents, creating affordability concerns for those residents as well.
- The Medicaid rate is not adequate to cover the staffing needs, including nursing staff.
- Funding for Choices for Care High Need participants is not guaranteed.<sup>23</sup>
- Growth of the sector is slow because there is insufficient capital to build ALRs.

The Task Force was told that ALRs are a wonderful model but that it will take some time before the long-term care environment adequately supports this option.

### **3. ADULT DAY SERVICES**

The Community of Vermont Elders (COVE) *Reimbursement Practices and Issues* report provides an excellent description of adult day services in Vermont:

“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.’”

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

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<sup>22</sup> Presentation to the LTC Sustainability Task Force by Nancy Eldridge, Cathedral Square Corporation, July 13, 2006.

<sup>23</sup> Funding for people who meet the High Need criteria for the Choices for Care waiver is available as the budget allows; therefore, people meeting the High Need criteria have a greater likelihood of being placed on a waiting list. If an ALR or RCH admits an individual whose care needs progress to High Need level, there is no guarantee about when funding will be available from the Choices for Care waiver for that individual. As of January 15, 2007, there was no waiting list for the High Need group.

centers also have an 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*.

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."<sup>24</sup>

Adult Day programs receive funding through a complicated mix of Medicaid State Plan services (Day Health Rehabilitation Services – DHRS), Choices for Care waiver participation, private pay clients, Veteran's Administration and a small amount of state funds.

Adult day providers reported several challenges to their future viability:<sup>25</sup>

- Additional staff are needed to meet the increased complexity of client needs.
- Medicaid reimbursement rates do not cover actual costs, and Medicare does not pay for adult day services. Some of the adult day centers operate at a loss and are "constantly fundraising just to keep the doors open."<sup>26</sup>
- The level of reimbursement makes renovations, improvements and expansion very challenging, at a time when more adult day services are needed. Families are asking for weekend respite, overnight respite and expanded week-day hours, but with the current reimbursement, expansion is not possible.
- Adult day providers compete with other parts of the health care and long-term care system for nursing staff and direct care workers, but cannot offer competitive wages.
- Transportation costs, always difficult to manage, have become a major expense and a barrier to attendance for some participants.

#### **4. HOME HEALTH AGENCIES**

Vermont has 12 home health agencies: 11 not-for-profits and one for-profit. According to the Vermont Assembly of Home Health Agencies (VAHHA), which represents the 11 not-for-profit agencies, the service mix has changed radically over the past 20 years.<sup>27</sup> Services

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<sup>24</sup> *Reimbursement Practices and Issues in Vermont's Long Term-Care Programs*, op cit.

<sup>25</sup> Presentation to the LTC Sustainability Task Force by Peter Coutu, Riverside Life Enrichment, July 13, 2006.

<sup>26</sup> Ibid.

<sup>27</sup> Presentation to the LTC Sustainability Task Force by Peter Cobb, Vermont Assembly of Home Health Agencies, July 13, 2006.

provided by home health aides, Choices for Care waiver attendants and homemakers now make up more than half of the visits provided by home health agencies and RNs provide fewer visits than home health aides. The Choices for Care waiver is the driving force behind the more recent changes.

Home health agencies are a critical component of the long-term care system, providing State Plan Medicaid services (nursing services, physical therapy, speech therapy, occupational therapy, social work) and Medicare services that augment the services provided by the Medicaid waivers. Home health agencies also provide personal care attendant services and respite and companion services under the Choices for Care Waiver.

Over the past 15 years, the total number of people served each year by the home care agencies has grown dramatically from 13,624 people served in 1989 to 21,822 served in 2004, a 60% increase. The number and the percentage of the patients who were 65 or younger have increased the fastest. In 2004, 10,567 home care patients were under 65, 48.4% of the total, compared to 3,610 in 1989, just 26.5% of the total served. The vast majority (63.7%) of home care patients are women. That percentage has held steady for 25 years.

VAHHA provided the following information about home health agency revenues. Agencies reported a higher proportion of their revenue comes from government payments than any other long-term care service sector.<sup>28</sup> Medicaid represents a continually growing percentage of revenue. While Medicare is still the largest revenue source, it is currently showing a downward trend. Private insurance and private pay represent a small percentage of revenues. A \$1.6 million operating loss by the home health agencies as a group in FY03 has grown to an operating loss of \$5.7 million in FY05. Until FY05, the agencies were able to more than make up that loss from other sources. Most of the loss can be attributed to the growth in the number of Medicaid clients. (According to DAIL, most of the \$3,596,953 loss was attributable to programs other than the Choices for Care waiver, which showed a net gain in FY05 of \$183,408 for the agencies.) VAHHA members believe if this trend continues, home health agencies will be unable to serve every Vermonter in need.

VAHHA reported that the following issues are important to providing continued quality care to LTC recipients:

- Staffing – There is a serious shortage of nurses, home health aides, licensed nursing assistants, homemakers, respite workers and personal care attendants. Home health agencies are challenged to provide wages and benefits competitive or comparable to those offered by acute care facilities.
- Training – Many of the consumers receiving services through the Choices for Care program are very sick and extremely frail and present great challenges to the direct care workers who provide most of the assistance needed. Keeping these entry level staff adequately trained will be a great challenge to the agencies.

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<sup>28</sup> AHS notes that the Developmental Services providers and TBI providers receive 95% of their revenue from government payments.

- Reimbursement – Reimbursement from the state must cover reasonable costs and must be high enough so that the agencies can pay a livable wage and benefits to Direct Care Workers.
- Presumption of Eligibility – There is a significant gap between the initial assessment and the final approval by Medicaid for Choices for Care enrollment. Home health agencies cannot afford to provide services for consumers who are not eligible for services. A presumption of eligibility is needed for all Choices for Care participants who are clinically eligible but are waiting for financial eligibility.

## 5. AREA AGENCIES ON AGING (AAAS)

The five non-profit Area Agencies on Aging (AAAs) noted that they see this study not as an exercise in preserving the status quo, but rather as an opportunity to build a model long-term care system that will require change from everyone, from nursing facilities to senior centers.<sup>29</sup>

Nationally, there is a decrease both in the number of frail elders and in disabilities among elders because older people are staying healthy longer; however, this is offset by the increasing number of older people. The AAAs noted that demographic changes and changes in consumer preference that are taking place concurrently with the shrinking number of nursing facility beds point to a need to increase the capacity of the home and community based components of the long-term care system.

The AAAs contract with about 175 small, independent community based providers that provide meals, transportation, and other support services for Vermonters age 60 and over. Collectively, the agencies had a budget of about \$15.1 million in FY07. Approximately 40% of the collective AAA budget goes to the community based contractors and about 50% to meet personnel costs. Approximately \$1 million goes to family caregivers, assistive technology, home modifications, respite, and cash programs to help people stay independent. The balance supports AAA operations.

AAAs are largely dependent on federal Older Americans Act funds. They also receive some state and local funds and private donations. With the exception of case management services provided under the Choices for Care waiver, the Older Americans Act mandates that AAAs may not charge for services.<sup>30</sup> Their three largest programs are case management (Choices for Care and Older Americans Act), the Senior Helpline (information and assistance services), and nutrition programs. The AAAs also sponsor the State Health Insurance Assistance Program (SHIP), which has been instrumental in assisting Medicare beneficiaries with the Medicare Part D prescription drug program. The AAAs are partners with the Community Mental Health Centers in the Eldercare Clinician mental health program. Part of the AAA mandate under the Older Americans Act is actively to engage their communities in health promotion and disease prevention activities. They work closely with the senior centers to accomplish these activities. The AAAs have discussed forming a statewide organization to

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<sup>29</sup> Presentation to the LTC Sustainability Task Force by Ken Gordon, Northeast Kingdom Area Agency on Aging, July 13, 2006.

<sup>30</sup> New opportunities might be available through the newly reauthorized Older Americans Act.

provide fee for service case management and to fund raise collectively as other ways of increasing their revenue.

Key issues for the AAAs include:

- Level funding from the federal government for many years and lack of commitment for future increases. This affects the 175 small community organizations, like senior centers and other nutrition program providers who primarily depend on funding from the AAAs to provide services.
- The gap between available resources and cost of providing services to a growing population.
- Pressure to provide new services, e.g. Medicare Part D counseling, chronic care management, additional wellness programming, emergency management tasks, and additional support to informal caregivers.
- Inability to bill for services, except for Choices for Care waiver case management.
- Case management wage disparity. AAAs cannot compete with wages paid to case managers by home health agencies. They may not charge for case management services provided under the Older Americans Act.
- Vulnerable nutrition services. Demand for congregate meals is shrinking while the demand for home-delivered meals has stayed essentially level. These services are critical to maintaining seniors and younger adults with disabilities in the community, and the costs of providing these services continues to escalate. One hundred fifty-one (151) independent meal sites serve over one million meals per year and employ over 500 paid and volunteer staff. At current funding levels, the AAAs cannot increase funding to these community organizations.
- Minimal fund balances, largely due to the long stretch of level federal funding. None of the AAAs comes close to carrying the recommended fund balance necessary to weather financial difficulties.

## **6. VERMONT CENTER FOR INDEPENDENT LIVING (VCIL)**

The Vermont Center for Independent Living (VCIL) is a statewide non-profit organization that provides peer counseling, information and referral, and specific assistance (e.g., home modifications, home-delivered meals for adults under age 60) to people with disabilities, including those with psychiatric and cognitive disabilities. VCIL also provides technical assistance and local and systems advocacy to help make communities accessible and responsive to Vermonters with disabilities. The organization is staffed by people with disabilities. VCIL's ability to meet the needs of people with disabilities is limited by the inadequacy of the funds they receive. For example, the Home Access Program has a lengthy waiting list (177 people) and would need an additional \$2 million to meet the anticipated demand in 2007.<sup>31</sup> It would take \$1,327,500 to eliminate the waiting list at an average per project cost of \$7,500. An additional ten to 12 applications are received each month, driving the need for an estimated additional \$900,000.

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<sup>31</sup> Presentation to the LTC Sustainability Task Force by Deborah Lisi-Baker, Vermont Center for Independent Living, November 9, 2006.

Challenges facing VCIL include:

- There is no equitable method for allocating resources proportionately among services for elders and younger adults with disabilities. VCIL's total budget to provide statewide service and advocacy for people with disabilities is approximately \$2.4 million, which is roughly equivalent to the budgets of some of the smaller regional AAAs.
- Federal funding to support VCIL's federally mandated peer counseling and I&R programs has been level-funded for 14 years.
- Like other non-profit organizations that provide “core” or supportive long-term care services, VCIL does not receive inflationary increases to meet increased costs. This results in non-competitive wages, frequent staff turnover, and erosion of services.

## **7. INDEPENDENT CARE PROVIDERS**

In response to consumer requests and the need for more direct care workers, in 1997-1998, DAIL approved what are known as the consumer- and surrogate-directed options. These options for managing one’s personal care services are available to individuals receiving their Choices for Care services and supports at home. Consumers or their surrogates hire, train and supervise their direct care workers. Sixty five percent (65%) of the personal care services provided to home-based Choices for Care participants are now delivered under these options and thirty-five percent (35%) of the personal care services are delivered by home health agencies. The independent care providers work directly for the consumer, who is the employer of record, rather than for an agency. These care providers are paid \$10/hour and do not receive any benefits. They are also responsible for their travel costs to and from the consumer’s home.

Additional information is provided below concerning the Attendant Services Program, which was the first DAIL program to allow consumers to employ their care attendants.

## **8. HOUSING BASED SERVICES**

Many older Vermonters and adults with disabilities move to congregate housing settings when their individual circumstances have made it difficult for them to remain in single family homes or apartments in the community. There are nearly 200 congregate housing settings in Vermont for elders or people with disabilities; about half of these residences offer some services to residents. Services may include on-site staff such as resident service coordinators, activities coordinators, and live-in resident managers. Resident service coordinators tend to have a high level of information regarding programs and services available to residents including information on transportation, Medicare and Medicaid. Resident managers live on-site and are typically responsible for keeping the building secure, addressing physical plant emergencies and calling for emergency help in the case of a medical emergency. Resident managers are not trained to provide personal care or medical assistance.

Other housing based services may include a wellness program; meals on a daily, weekly or monthly basis, homemaker services; and community events. The Institute for the Future of

Aging Services (IFAS)<sup>32</sup> describes this type of housing as "affordable housing plus services", which they define as unlicensed settings including limited equity co-ops, shared housing, selected mobile home parks, and some naturally occurring retirement communities (NORCs). In a paper released in October 2005, IFAS proposed the following criteria for the ideal "affordable housing plus services" program:

- It would start with a shared philosophy between residents and their families, the housing property and the community to "do what it takes" to help lower income older adults age in place
- It would provide residents who wish to age in place with access to a full spectrum of primary, preventive and chronic care, as well as supportive and personal care services.
- It would be resident-centered:
  - a. Resident choice and privacy would be assured.
  - b. Decisions to accept or reject services would be voluntary.
  - c. The role of the housing provider and community services agency would be to partner with residents who want to stay.
  - d. Services linkage strategies would be flexible, responding to the local environment; and organized, funded and implemented according to the capacities of various partners and the political and policy environments in which they are located.
  - e. It would be adaptable to changing needs.
- The system would capitalize on the existing resources of the resident and his or her family, the housing community, the neighborhood and community at large, as well as the resources available from municipal, state and federal government sources.
- It would take advantage of economies of scale, thereby increasing services efficiency and making resources go further.

Resident service coordinators are funded by three sources: the Department of Housing and Urban Development's Resident Service Coordination grant program; Vermont's Housing and Supportive Services Program; and by the operating revenues of housing providers.

The Housing and Supportive Services Program (HASS) is funded entirely with state funds. Most of the funding from the original program was transferred to the Choices for Care waiver to help fund Homemaker services for the Moderate Need group. The original intent of the HASS program was to fund a service coordination function within congregate housing settings and to provide services that would help participants retain their independence and their housing (e.g. homemaker services, health screening and assessment, foot clinics, wellness activities). The remaining funds that were not moved to the Choices for Care waiver (\$350,000 in state funds) may still be used for these purposes. A housing and policy group is meeting to examine the most efficient and effective way to provide service coordination, a "protective presence," nursing assessment and other services with the goal of assisting congregate housing residents to age in place. One of the challenges will be to determine how to meet this need for all residents in a congregate setting where only a small percent of residents receive Choices for Care services. Using state funds for all residents would not be financially feasible.

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<sup>32</sup> <http://www.futureofaging.org/>

Housing Plus Services takes many forms in Vermont including home sharing, shared housing, and housing where services are co-located. Vermont has two HomeShare programs, one serving Chittenden County and parts of Addison and Grand Isle Counties, and a second in Central Vermont serving the greater Barre-Montpelier area (with future plans to serve the entire central region). Homeowners who are frail elders or who have disabilities can be matched with people who want to share a home in exchange for providing some services to the homeowner. The goal is to expand these models to other parts of the state.

There are a number of shared housing models in Vermont such as Ruggles House in Burlington, where frail elders live together, sharing meals and a common community. Any needed services, such as home care, are provided by outside organizations. Similar models exist at the Joslyn House in Randolph and Park House in Rochester.

Each model points to the need for housing that is paired with the supportive services necessary to allow residents to age in place as their care needs increase.

## **9. ATTENDANT SERVICES PROGRAM (ASP)**

The Attendant Services Program started in 1980 and was heavily influenced by the independent living movement. ASP provides funding for personal care assistance for adults with severe and permanent disabilities. The original concept of the program was to help individuals with disabilities obtain the personal care needed to enter or return to the workplace. The program has expanded over the last 25+ years and now includes a Medicaid State Plan component and serves many elderly Vermonters as well as younger adults with disabilities.

This program is unique in that was originally the only program designed to enable younger persons with disabilities to enter or re-enter the workforce. It was expanded in 1984 when VCIL performed a study of younger nursing home residents and began an intense effort to help these individuals living in nursing homes to leave those nursing homes and embark on an independent lifestyle. Society is accustomed to thinking of “long-term care” in terms of frail elders with disabilities using long-term care. The role of long-term care and support in enabling persons with significant disabilities to contribute to the sustainability of the system through their own wages, as well as adding to the diversity of the work force, is often overlooked.

Choices for Care consumer- and surrogate-directed options are patterned after the ASP program. A unique component of the ASP is the provision that allows spouses to be paid caregivers. This is often critical to the participant’s employment because a care attendant is living in the home and can be there to get the person with the disability ready for work instead of having to wait for a paid care provider to arrive.

Several years ago, Personal Care Services was added to the list of State Plan Medicaid services for people who are able to manage their own care (i.e., hire, train, supervise and discharge their care attendants). About 90 participants receive this type of funding. State funds pay for services for the remaining 163 participants. The Legislature increased funding for the program on July 1, 2006, resulting in an increase in the wages for attendants. Personal care attendants receive \$9.00/hour for their first six months of work. The rate then increases to

\$9.50/hour if the individual stays with the same participant. Attendants do not receive benefits or reimbursement for travel costs. These wages still lag behind the \$10.00/hour rate paid to Personal Care Attendants who work directly for participants in the Choices for Care waiver. ASP participants consistently report difficulties in recruiting and retaining attendants.

## **10. ELDERCARE CLINICIAN PROGRAM**

The goal of the Eldercare Clinician Program is to improve the well-being of adults age 60 and older through the provision of outreach mental health services that will increase or maintain elders' quality of life and maximize their independence. This program is designed to reach out to older Vermonters who are unable or unwilling to attend clinic-based mental health services.

The Eldercare Clinician Program began providing services in FY2000 after extensive grassroots efforts to illustrate the need for mental health outreach services for older Vermonters. A successful pilot program had shown that many isolated older adults who needed mental health services but who were uncomfortable seeking services in traditional settings or unable to access those services could benefit from home-based services. Adults aged 60 and older experience more losses than younger populations (e.g., decline in physical health, death of family and friends, decline in cognitive functioning, changing financial situations, changes in housing, loss of independence). Many are facing end of life issues and there are limited natural supports available for this age group.

Eldercare Clinicians provide home-based counseling and support services to isolated older adults for treatment of depression, adjustment disorders, anxiety disorders, dementia, schizophrenia and substance abuse. Home-based services also allow the clinician to observe the individual functioning in his/her home, which might provide new insights. Eldercare clinicians also provide information, counseling and assistance to family caregivers to help them continue in their caregiving role. Early intervention can prevent psychiatric hospitalizations and suicide in this population.

This is a statewide program, serving all 14 counties. It is a collaboration at the local, regional and state levels including Vermont's Area Agencies on Aging (AAAs), Community Mental Health Centers (CMHCs), the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Health, Division of Mental Health (DMH). Funding is a complex mixture of State general funds (\$250,000/year), fee-for-service Medicaid and some Medicare reimbursement, and a small amount of commercial insurance reimbursement. In FY2006 the majority of the clients (83%) had Medicare coverage, 52% had Medicaid coverage and 25% had other insurance. Eight percent of those served had no insurance or did not indicate their insurance coverage.

Services are provided by seven (7) full-time clinicians and 11 part-time clinicians. A geriatric psychiatrist provides training and clinical supervision for Eldercare Clinicians. The average caseload ranges from 8-38 clients, depending on the number of hours worked by each clinician. Since program inception, the number of persons served annually has remained relatively consistent. 485 adults were served in FY 2006 (unduplicated count). Most of the clients were female, (74% female, 26% male), with the greatest number in the 80-84 age cohort.

This program faces several challenges, including the limited amount of funding available to provide services to an ever-increasing older population. In order to stretch the available dollars, some agencies have limited services to Medicaid beneficiaries only. Medicare will pay only for a certain set of services. In addition, Medicare reimbursement rates are limited to 50% of costs, leaving the other 50% to be paid by the older adults who often do not have the means to pay the co-payment. Medicare reimbursement is limited to Licensed Clinical Social Workers (LICSWs) and Ph.D. psychologists; some of the Eldercare Clinicians do not have these credentials.

Staff turnover is a problem because the Community Mental Health Agencies often have difficulty matching what clinicians can earn in the private sector. Turnover has an obvious negative impact on the relationships established between the clinician and the elder.

## **11. TRAUMATIC BRAIN INJURY (TBI) PROVIDERS**

The TBI Medicaid waiver program started October 1, 1994 and serves individuals 16 years of age and older. Prior to this waiver, persons with TBI were placed in out of state institutions, which took a toll on their families and was very costly for Vermont taxpayers. Although most of the current 49 participants receive short-term services, a long-term option for individuals requiring ongoing intensive one-to-one support is available to a limited number of people. The program provides case management, rehabilitation, community supports, respite, environmental and assistive technology, crisis support, psychology and counseling services, employment support, and pre-admission planning.

Providers report difficulty providing services under the current rate structure. The reimbursement rate for case management (\$36/hour) was set in 2001 and an increase is planned for SFY08; however, the amount of that increase has not yet been determined. The reimbursement rate for community supports (24-hour supervision) and respite is \$62.50 for a 24-hour period. Many providers have declined referrals due to the inability to provide supports at that rate. This rate is substantially lower than the reimbursement rate for shared living 24-hour support through Developmental Services. The reimbursement rate for psychological and counseling services is half the rate charged by psychologists/counselors for similar services delivered to non-waiver clients.

There are five people on the waiting list for long-term services and one on the waiting list for short-term rehabilitation services. DAIL anticipates the need to develop additional capacity each year for the foreseeable future. This number could increase if some returning veterans qualify for services.

The number of participants served by the program has grown by 38% in the last three years. To meet the anticipated need as the program continues to grow, more providers will be required. Additionally, the need for providers that can provide 24-hour supervision has increased. Many of the providers such as PRIDE, Lenny Burke Farm, and Riverview Life Skills Center are already at capacity.

Although there are many seasoned professional providers of traumatic brain injury

services throughout Vermont, specialty training on the unique medical, social and dual (sometimes triple) diagnosis of each individual creates a constant need for ongoing professional training. Many home health agencies approved as TBI providers receive referrals on an infrequent basis, and due to the low volume of TBI clients served by home health agencies, staff wear many hats and turnover in the area of TBI case management can be high. Additional TBI training is critical for all service providers.

## **12. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

The Program for All-Inclusive Care for the Elderly (PACE) is based on the concept that consumers experience better health outcomes when their acute, primary and long-term care is coordinated and participant-centered. The PACE model is based in a PACE center. PACE is available for persons age 55 and older and will become an option under the Choices for Care waiver. Providers receive capitated rates from Medicare and Medicaid and may use those funds flexibly to provide care, support and services for the participant. The provider accepts the risk for all care and services needed by the participants. The participant and the interdisciplinary team are at the heart of the program. Vermont's first PACE site in Chittenden County is expected to start enrolling participants in early 2007 and a second site is scheduled to open in Rutland later this year. This model, which has been successful in urban areas, will offer a new option for rural Vermont as it is expanded across the state.

Because enrollment is limited to people age 55 and over, younger adults with disabilities cannot participate in PACE. Therefore, DAIL is studying the feasibility of another integrated model (integrating acute, primary and long-term care and using capitated rates from both Medicare and Medicaid), which would not be based at a center, but would still use an integrated care team and a consumer-centered approach to care. Enrollment would initially be for individuals age 18 or over with both Medicare and Medicaid coverage (dual eligibles) who meet the criteria for nursing facility level of care.

## **13. INFORMAL CAREGIVERS (FAMILY AND FRIENDS)**

The majority of long-term care services in Vermont are provided by friends and family. Publicly funded services depend heavily on these caregivers. Taxpayers' dollars alone could not finance long-term care. The many hours of service that informal caregivers provide are essential to the system as a whole.

According to a recent analysis of the value of family caregiver services by the Family Caregiver Alliance, the value of "free" services provided by family caregivers to their chronically ill, disabled or aged family members has grown to \$306 billion nationally, a 19% increase in the past four years.

The Alliance states that, "Families are the mainstay of our long-term care system, with nearly 80 percent of long-term care provided in the home, not in institutions. That care includes everything from cooking meals to changing feeding tubes, from dispensing medications to managing incontinence. Were families to cease providing this care, the enormous burden placed on our healthcare system would be crippling. We need to respect and honor not only the

staggering dollar value of the care these families provide, but also their dedication to the challenging and sometimes exhausting job of caring for their loved ones.

Family caregivers provide a vast array of emotional, financial, nursing, social, homemaking and other services on a daily or intermittent basis. While some family caregivers provide 24/7 care for loved ones who require assistance for all daily living activities, others may provide care on a part-time basis. Family caregiving can extend for a few years or a lifetime.”<sup>33</sup>

The Alliance estimates that Vermont has 64,277 family caregivers who provide 69 million hours of care each year at a market value of \$683 million.<sup>34</sup> Vermont relies heavily on these caregivers, since public programs alone could not meet Vermonters’ long-term care needs.

#### **14. RESPITE SERVICES**

Respite opportunities are needed to enable these caregivers to “recharge” and continue their important work. Respite is available on a limited basis through two programs administered by the five AAAs: the Dementia Respite program and the National Family Caregiver Support program. The FFY06 funding for the Dementia Respite program is \$446,150 (\$250,000 in state funds and \$196,150 from a federal grant). Respite is also available through the Choices for Care waiver (maximum of 720 hours/year) at home, in a residential care home or in a nursing facility. Adult day centers are also an important source of respite for family caregivers and some centers would provide evening, overnight and weekend services if additional resources were available.

The reimbursement rate for consumer/surrogate directed in-home respite workers under the Choices for Care waiver is \$9.88/hour with no benefits. Consumers report that it is difficult to find workers willing to work for these wages. As a result, respite hours go unused in care plans and informal caregivers find it difficult to schedule time away for their caregiving duties. Home health agency-directed respite care is reimbursed at \$20/hour. This rate was last increased in October 1, 2005.

#### **ADDITIONAL SERVICES, PROGRAMS AND PROVIDERS THAT SUPPORT ELDERS AND ADULTS WITH DISABILITIES**

Additional services, programs and providers support elders and adults with disabilities to live as independently as possible. Each supportive component plays an important part in making the whole system work. For instance, a person who elects to receive his/her long-term care services at home might also benefit from attendance at an adult day center; however, attendance at the center is not possible without adequate transportation services. The Task Force agreed that the following components provide critical support to people receiving in long-term care services.

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<sup>33</sup> National Family Caregivers Association and Family Caregiver Alliance, November 9, 2006 press release.

<sup>34</sup> National Family Caregivers Association and Family Caregiver Alliance (2006). *Prevalence, Hours and Economic Value of Family Caregiving, Updated State-by-State Analysis of 2004 National Estimates* by Peter S. Arno, PhD [http://www.thefamilycaregiver.org/pdfs/State\\_Caregiving\\_Databystate2006.pdf](http://www.thefamilycaregiver.org/pdfs/State_Caregiving_Databystate2006.pdf)

- "Bricks and mortar" housing production
- Transportation
- Community based volunteer programs (e.g. Neighbor to Neighbor, Senior Companions, faith-based initiatives)
- Services for persons who are blind or visually impaired and services for persons who are Deaf, hard of hearing or late-deafened
- Health promotion services
- Benefits counseling.

## 1. "BRICKS AND MORTAR" HOUSING PRODUCTION

Vermont's housing stock is some of the oldest in the country, which means residents face increased expenses for energy and upkeep. In addition, Vermont's rural nature and lack of public transportation create additional challenges for people who do not drive. Others simply want the security and social opportunities of living close to others in a congregate setting.

Waiting lists for seniors seeking affordable housing in Vermont vary significantly based on geographic location and specific property. For some housing projects in certain areas of Vermont, the wait could be a month or less. For other senior projects, the wait could be up to three years. A waiting list of one year could be characterized as common.

A recent search of the Vermont Directory of Affordable Rental Housing (DoARH) was initiated by DAIL and carried out by the staff at Vermont Housing Finance Agency (VHFA). That search determined that of the current listing of 11,755 affordable rental units in 488 separate properties, there are approximately 5,800 apartments in almost 200 properties that are designated for occupancy only by elders or adults with disabilities.

The DoARH website is an excellent resource that Vermonters can easily search by town or county.<sup>35</sup>

## 2. TRANSPORTATION

Transportation is a key factor in whether elders and people with disabilities can access needed health care and other services, participate in their communities, connect with families and maintain their independence and well-being.

Adults strongly prefer and depend heavily on private vehicles for their transportation. This is particularly true for those living in more rural areas, where people need to travel farther distances to access services and where there is a lack of public transportation. A recent report by AARP notes that 74% of older adults (age 65+) are licensed drivers.<sup>36</sup>

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<sup>35</sup> [www.housingdata.org/doarh/index.php](http://www.housingdata.org/doarh/index.php)

<sup>36</sup> *Vermont State Plan on Aging for Federal Fiscal Years 2007 – 2010*. DAIL, 2006. Information in this section taken from the Vermont State Plan on Aging has been modified to include adults with physical disabilities.

The number of licensed drivers and the miles traveled decreases with age. In addition, those who experience poor health and/or disability are more likely to experience difficulty in mobility. This increases the likelihood of isolation and inability to access services, visit friends and participate in community life. In our predominantly rural state with its shortage of public transportation assistance, many older Vermonters and adults with disabilities experience difficulties accessing transportation services on a regular basis.<sup>37</sup>

For those who do not drive and who do not have ready transportation assistance from family or friends, public transportation is extremely important. Vermont's public transportation providers are challenged to design and develop creative solutions to meet the needs in rural communities, such as demand response services or route deviation services.<sup>38</sup>

In many regions of the state, volunteer drivers play an essential role in helping elders and people with disabilities access the transportation they need to maintain their mobility and independence. According to the Vermont Public Transportation Association, in 2005 volunteer drivers provided about 30% of all Medicaid non-emergency, medical transportation trips and drove over 5.5 million miles.<sup>39</sup>

In addition to needing adequate amounts of and creatively designed public transportation, it may be necessary to offer special training in the use of public transportation to older Vermonters and persons with disabilities who have never used it before. Transportation providers also need training regarding the special needs of elders and people with disabilities as well as clear guidelines for making reasonable accommodations for elders and people with disabilities when needed.

Area Agencies on Aging provide much needed support for older adult transportation and invest considerable time and effort working with the transportation providers in each region of the state. Some AAAs have had to develop new methods to manage their transportation resources because of the increasing demand for transportation, coupled with skyrocketing fuel and insurance costs, by limiting trips or prioritizing the types of trips they can subsidize. They have also tried to coordinate trips to and from a given region by requiring that people from the same town plan trips and ride together on a specified day of the month, rather than providing multiple individual rides.

### **3. COMMUNITY BASED VOLUNTEER PROGRAMS**

Community based volunteer programs fill in where publicly financed programs fall short. The home-delivered meals program for elders and persons with disabilities receives funding through the federal Administration on Aging and state funds; however, the funding does not meet the costs of purchasing the food and preparing and delivering over 1 million meals each year. The AAAs and VCIL depend heavily on volunteer drivers to deliver the meals. For many home-bound elders, the home-delivered meals driver is their sole human contact for the day. Volunteering provides benefits both to the volunteer who reaps the reward for improving life in

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<sup>37</sup> Ibid.

<sup>38</sup> Ibid.

<sup>39</sup> Ibid.

his/her community and for the elder or person with a disability who receives a healthy meal, some brief social interaction and a quick check-in by a volunteer driver who will report back if things do not seem quite right.

Volunteer programs are not without costs, a fact often overlooked by those who tout the value of these programs. There are administrative costs such as recruitment and retention activities, reimbursement for mileage, and volunteer training and supervision. The Task Force recognizes that public programs alone cannot fill the need and that there is a continuing need to cultivate and support caring communities who are willing to help their friends and neighbors.

#### **4. SERVICES FOR PEOPLE WHO ARE BLIND OR VISUALLY IMPAIRED AND SERVICES FOR PEOPLE WHO ARE DEAF, HARD OF HEARING OR LATE-DEAFENED**

The Vermont Association for the Blind and Visually Impaired (VABVI) is a statewide non-profit that provides rehabilitation and other services to visually impaired people of all ages. About 80% of VABVI's clients are adults, the majority age 55 and older. VABVI's mission is to enable Vermonters with vision problems to achieve and maintain their independence. Toward that end, the organization provides skills training, adaptive equipment and materials, orientation and mobility, volunteer drivers, low vision evaluations, and furnishes materials in Braille, audiotape and large print format.

Over the last few years, VABVI has seen more than a 60% increase in the number of people they serve. It is estimated that the number of visually impaired people will almost double between now and 2030 as a result of Vermont's aging population.

According to VABVI, the need to increase staff numbers and retain good staff to meet this need will be challenging. There has not been an increase in federal funding for over 15 years. While the organization receives some state funds, VABVI reports that without inflationary increases, it cannot meet increasing costs. They also report that the lack of regular funding increases makes it difficult to provide competitive wages, which results in frequent staff turnover and staff positions that take longer to fill, limiting the number of people they are able to serve.

The Vermont Center for the Deaf and Hard of Hearing (VCDHH) provides a wide range of services: mental health services, Parent Infant Program, American Sign Language Program, Vermont Interpreter Referral Service, and Deaf Victims Advocacy Service (DVAS). According to the VCDHH, it struggles each year to find the funding to provide services and meet demand. VCIL's Deaf Service Program offers peer counseling and advocacy services.

#### **5. HEALTH PROMOTION SERVICES**

Health promotion and disease prevention, which have been a focus of the efforts of the Area Agencies on Aging and the Home Health Agencies, are now receiving more attention because of the Governor's chronic care initiative known as the Blueprint for Health. Encouraging and teaching older Vermonters and people with disabilities to take responsibility for their health can result in an improved quality of life and lower costs for the health care system.

Because federal funding from the Older Americans Act has been essentially level for many years, the full potential of these prevention activities has never been realized.

## **6. BENEFITS COUNSELING**

Benefits counseling is a service that helps ensure that older Vermonters and people with disabilities are aware of the public benefit programs to which they are entitled. In addition, case managers and counselors assist with eligibility and enrollment applications, re-certifications and navigating the state and federal systems. The AAAs provide benefits counseling for individuals age 60 and over, without regard to income status. VCIL provides assistance for adults with disabilities.

## **VII. SERVICES UNDER DEVELOPMENT**

Three initiatives under development will add new long-term care service options for elders and adults with disabilities in Vermont.

### **A. AGING AND DISABILITY RESOURCE COLLABORATIVES (ADRCs)**

The Area Agencies on Aging have a well-developed system for delivering complete and unbiased information, referral and assistance (I/R/A) to older Vermonters and their families. The Senior HelpLine provides a toll-free number that automatically routes the caller to his/her local AAA. Comparable systems do not exist for other populations. DAIL received a three-year \$800,000 grant to develop a system of Aging and Disability Resource Collaboratives (ADRCs) to provide seamless access to long-term care information, referral and assistance (I/R/A) for older Vermonters, younger adults with physical and developmental disabilities or traumatic brain injury by improving and expanding the I/R/A functions performed by the Area Agencies on Aging (AAAs) in collaboration with other local partners.

Consumer and key stakeholder input is critical to the process for developing ADRCs. Key partners include AAAs, the Vermont Center for Independent Living [VCIL], the Office of Vermont Health Access, the Department for Children and Families, Designated Agencies, Brain Injury Association of Vermont and Vermont 2-1-1.

Goals of the grant are to: (1) improve the I/R/A system for older Vermonters; (2) design a streamlined eligibility process for Medicaid and Medicaid Long Term Care; and (3) create a seamless link between the ADRCs and Medicaid eligibility determinations. All AAAs will use the same I/R/A software and plans will be put in place to market I/R/A services to private-pay consumers. ADRC services will be expanded to include younger people with disabilities, individuals with traumatic brain injuries and individuals with developmental disabilities.

### **B. ADULT FOSTER CARE (24 HOUR COVERAGE IN HOME-BASED SETTINGS)**

DAIL has long been interested in developing a home-care option that mirrors services offered to persons with developmental disabilities through contracted home providers. There are

still some details to be worked out, but DAIL is close to being able to offer this option to participants in the Choices for Care waiver.

Adult foster care will mean 24hour home care services for an individual 18 years of age or older provided in the residence of a home care provider. Home care services will include room, board, safety, household services and any specialized services to meet the unique needs of the individual. Adult foster care will be provided to no more than two individuals in the same home. DAIL does not expect this option to be widely utilized.

### **C. MYCARE VERMONT – HEALTH AND LONG-TERM CARE INTEGRATION PROJECT**

The lack of coordination among acute, primary and long-term care services has often left consumers with poor health outcomes, lower than expected quality of life and has increased the tax burden for all Vermonters. DAIL received a three-year planning grant from the Centers for Medicare and Medicaid Services (CMS) to develop a new service option that would integrate and coordinate acute, primary and long-term care using both Medicare and Medicaid dollars under a capitated reimbursement system. Participating organizations would use an interdisciplinary care team and a consumer-driven model of service delivery to ensure the best possible outcomes for the participant.

## **VIII. LONG-TERM CARE CAPACITY FOR THE NEXT 10 YEARS**

The Task Force reviewed forecasting information from DAIL showing the predicted ten-year capacity needed for certain components of the long-term care system: nursing facility resident beds, adult day services, enhanced residential care, assisted living, homemaker services, attendant care (ASP), personal care under the Choices for Care waiver, and assistive community care services. The projections, while portraying a creditable picture of the future based on the changing demographics and the vision of a more balanced long term care system, could change due to the availability of new and expanded home and community based services, medical advances and changes in consumer preferences.

### **A. HOME AND COMMUNITY BASED SERVICES CAPACITY (see Appendix C for the forecasting spreadsheet)**

The Task Force wanted to project the capacity needed for a more balanced long term care system in eight major home and community based components over the next 10 years. Included in the forecast are: personal care under the Choices for Care waiver; adult day services; enhanced residential care; attendant care (ASP); homemaker services; assistive community care services (ACCS); assisted living residences; and private pay residential care capacity.

The Task Force adopted a methodology created by DAIL that is based on the concept of a statewide projected service use rate for 2015. The 2015 Projected Use Rate was derived by taking the 2015 projected use (i.e. number of participants) and dividing it by the 2015 projected

number of non-institutionalized people with disabilities,<sup>40</sup> 18 years of age or older in Vermont.<sup>41</sup> Using this approach, a 2015 Projected Use Rate state average was calculated for each of the eight services/programs and then applied to each county. In order to achieve the vision of a more balanced long-term care system, each county would have to perform at either the state average or the county's 2015 Expected Use rate,<sup>42</sup> whichever is higher.

According to the forecast, all counties would need to increase their capacity, some more dramatically than others. Many home and community based providers reported that the current reimbursement rates make it difficult to meet the current needs and that expanding services would be very challenging.

### **Nursing Facility Capacity (see Appendix D for the forecasting spreadsheet)**

The Legislature asked the Task Force to forecast the number of nursing facility beds to meet the projected need over the next 10 years reported by region. Appendix D depicts that scenario by county, utilizing Vermont's 2005 ratio of licensed nursing facility beds per one hundred people with disabilities age 18+ and applying the 2005 ratio to 2015. Were Vermont to have the same ratio of resident beds to people in 2015 as it did in 2005, there would be 369 fewer nursing facility beds. Under this scenario, several of Vermont's most "over-bedded" counties would experience the greatest changes. (Bennington would have 203 fewer beds, Washington would have 100 fewer beds and Orleans would have 56 fewer beds.) The reader should be aware that any projections are subject to changing consumer preferences, medical advances and the creation of new and/or expanded options for home and community based care.

## **IX. CREATING A SYSTEMATIC APPROACH TO REIMBURSEMENT FOR HOME AND COMMUNITY BASED LONG-TERM CARE COMPONENTS**

The Legislature asked the Task Force to determine whether or not indexing is an appropriate method of sustainable funding for home and community based services. Indexing is defined as a method of calculating an appropriate annual increase. Most national indices, e.g. Consumer Price Indices or Health Care Index, are constructed using many separate expenditure categories that are then assembled in a "market basket" index.

The white paper prepared for COVE by the Paraprofessional Healthcare Institute<sup>43</sup> clearly demonstrates that there is no systematic approach to setting the reimbursement for each component of the home and community based part of the long-term care system. For over 15 years, a very structured reimbursement system has existed for nursing facilities. The reimbursement system has undergone changes at least twice during that time period and another study of the nursing facility reimbursement system has just been completed. An annual inflation

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<sup>40</sup> Disability in this context is defined as needing assistance with 2 or more activities of daily living (ADLs).

<sup>41</sup> Includes all populations and payers.

<sup>42</sup> The 2015 Expected Use numbers are taken from Table 5 of DAIL's *Shaping the Future 2005-2015* report. The projections in *Shaping the Future* are revised annually.

<sup>43</sup> *Reimbursement Practices and Issues in Vermont's Long-Term Care Programs*, op cit.

rate, rebasing of cost factors, the case mix (acuity level) of the residents and many other elements go into creating the rate for each nursing facility.

There is no similar system for home and community based providers. As a result, providers often wait years for rate increases, eroding their ability to provide services, retain staff and expand their services and programs to meet the increasing demands. Future systematic rate increases alone, if applied to the current inadequate base rates, would inevitably fall short of the desired outcome of sustainability for some providers. According to the Area Agencies on Aging for example, given the growing number of older adults in Vermont and the flat growth in federal support for programs serving the elderly, the state's Area Agencies on Aging would actually be required to reduce their services if future increases were based solely upon current base rates. Other long term care service providers face similar circumstances.

The Task Force discussed the pros and cons of creating a cost-based reimbursement system for each home and community based (HCB) provider group. They identified the following issues with that methodology:

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

The Task Force discussed several different indices (e.g. Consumer Price Index and Health Cost Index) and agreed that the indices did not draw their data from sectors that were really relevant to home and community based service providers. The Task Force also considered the possibility of creating a Vermont-specific index that would capture changes in the relevant economic sectors, but there was not enough time to determine whether or not this approach was feasible. The group concluded that the prudent approach at this time was to use a straight percentage increase. (See recommendations on pages 37-41 for details.)

## **X. POSSIBLE VEHICLES FOR BRINGING ADDITIONAL FUNDING TO LONG-TERM CARE**

The Task Force reviewed two possible methods that hold some promise for bringing additional private funds to pay for long-term care services in Vermont. There are pros and cons to each subject area, so the Task Force did not endorse their adoption, but rather opted for further investigation.

### **A. REVERSE MORTGAGES**

Reverse mortgages are a mechanism that might help some people use the equity they have built in their homes to help maintain their independence and, if necessary, pay for long-term care expenses. This option is a solution for some people, but not for all. The individual receives

payments from the lending institution, based on the equity in his/her home and the structure of the reverse mortgage they select. Many lending institutions charge large upfront fees plus monthly service fees in addition to the standard interest rate. Reverse mortgages also use compounding interest rates. This option might be a solution for some individuals, but should be carefully researched with the help of an unbiased counselor. Massachusetts offers this type of counseling service through their Homeowner Options for Massachusetts Elders (H.O.M.E.), which will be examined more closely by DAIL.

## **B. LONG-TERM CARE INSURANCE**

Long-term care insurance is another product that, when appropriately purchased and used, can help people pay for part, if not all, of their long-term care needs. Most products now offered by insurance companies contain coverage for home care in addition to nursing facility care. The key is to purchase earlier rather than later in life to keep premiums low. Consumers must determine their ability to continue to pay premiums. Recent changes in regulations now ensure that even if a consumer is unable to continue to pay their premiums, they will still receive benefits up to the value of the premiums they were able to pay. Like reverse mortgages, long-term care insurance is a good solution for many people, but the pros and cons must be carefully weighed by each individual and adequate consumer protections must be in place.

The federal Deficit Reduction Act (DRA) offers a new option called *Long-Term Care Partnerships*. The goal of this option is to encourage consumers to purchase long-term care insurance by allowing them to use their full long-term care insurance benefit, still qualify for Medicaid coverage if they need it and retain more of their assets. An individual who has exhausted his/her long-term care insurance benefits may apply for Medicaid coverage and retain assets equivalent to the amount paid out for his/her care by the long-term care policy. Any long-term care insurance policy sold in Vermont must be approved by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). The 2004 Legislature passed legislation that allowed Vermont to move forward with this option as soon as federal legislation was passed, i.e. the Deficit Reduction Act. Vermont must now: (1) file a Medicaid State Plan Amendment with the Centers for Medicare and Medicaid Services (CMS); change the Vermont statute to bring it in line with the DRA; and BISHCA must file the necessary rule changes. That is expected to occur in January 2007.

## **XI. OBSERVATIONS AND RECOMMENDATIONS**

### **A. CRITICAL OBSERVATIONS OF THE LONG-TERM CARE SUSTAINABILITY TASK FORCE**

After hearing from DAIL and key providers in the long-term care system, the Task Force identified the following pertinent issues:

- Some government reimbursement rates are not sufficient to cover the costs of delivering services, which presents a major challenge for long-term care providers.
- There is additional need for residential care, assisted living, adult day services, case management and other home and community based services; however, expansion at the

time when many programs and services are financially vulnerable presents additional challenges.

- Strategic thinking and planning are required to “right-size” the nursing facility industry.
- There is no equitable method for allocating resources proportionately among services for elders and younger adults with disabilities.
- Employment compensation, benefits, and wage disparities across the long-term care system create difficulties in the hiring and retention of employees.
- Increased liability insurance premiums and Workers Compensation premiums are an issue for some providers.
- Many parts of the home and community based service sector feel pressured to do local fundraising, resulting in "contribution fatigue," saturation, and dilution of those efforts in communities.

## **B. RECOMMENDATIONS**

In addition to the recommendations from the over-arching Long-Term Care Sustainability Study, DAIL and the Long-Term Care Sustainability Task Force offer specific recommendations from three concurrent, related reports:

1. *The Nursing Facilities for the 21<sup>st</sup> Century Study*
2. *The Nursing Facility Reimbursement Study*
3. *The Direct Care Workforce Study (Interim Report)*<sup>44</sup> (final report due December 2007)

Task Force members wish to inform the Legislature that they have made every effort to accomplish the Legislature's charge to develop a long-range plan and recommendations to address the sustainability of Vermont's long-term care system. Their ability to respond fully to the Legislature's request has been limited by the time and resources available to accomplish their study of an extremely complex system. It is the consensus of the Task Force that is not possible to offer additional observations or recommendations at this time in light of the lack of objective, empirical data about many aspects of the home and community based system. The Task Force respectfully recommends that resources be provided to extend the study of the sustainability of Vermont's long-term care system.

The Department of Disabilities, Aging, and Independent Living and the Long Term Care Sustainability Task Force reached agreement about some but not all of the recommendations below. In the table below, the column on the left represents recommendations about which the Department and the Task Force have reached agreement. The column on the right represents areas where the Task Force differs from or augments the Department's recommendation.

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<sup>44</sup> *Direct Care Workforce Study, Interim Report.* DAIL, January 2007.

**RECOMMENDATIONS OF THE LONG-TERM CARE SYSTEM SUSTAINABILITY STUDY**

DAIL/Task Force Recommendations	Additional Task Force Recommendations ( <b>areas where agreement with DAIL have not been achieved or language augments the DAIL recommendation</b> )
<p>1. The rates for all providers of long-term care services in the Choices for Care 1115 demonstration waiver should be adjusted by an annual inflationary factor. This would include people participating in the consumer- and surrogate-directed options. Nursing facilities are currently the only Choices for Care provider for whom there are statutory inflationary increases. For SFY08, the recommended inflationary factor is 3.75%; an increase of \$613,745 in state funds. The Choices for Care case management rate, which is already \$65/hour, would not be increased.</p>	<p>1 a. The Task Force recommends that rates for all providers of long-term care services and supportive services should be adjusted by an annual inflationary factor. This includes but is not limited to services covered by Choices for Care (personal care, Enhanced Residential Care, adult day services, respite and companion services), Assistive Community Care Services (ACCS), Medicaid-funded adult day services, Attendant Services Program, homemaker services, some AAA services, some VCIL services, TBI waiver, Dementia grants, Eldercare Clinician program, and LTC Ombudsman. Nursing facilities were not included in this list because they already receive a statutorily required annual inflationary increase.</p> <p>The Task Force recommends an inflationary increase of 4% for FY08. The results of an across-the-board 4% increase to home and community based providers is shown in Appendix E. This amounts to an increase of \$1,147,993 in state funds.</p> <p>The Task Force also recommends that further study must be done to arrive at an equitable reimbursement system for the future. Because an in-depth study will take time, the Legislature should not wait for that system to be developed, but should increase current rates now so current problems are not exacerbated.</p>

<p>2. Review and increase funding to certain home and community based providers. Because some providers of home and community based services have not received increases for several years, initiating annual inflationary increases in SFY08 will continue to leave some home and community based providers in a vulnerable position.</p>	<p>2 a. The Task Force believes that annual inflationary increases, when applied to current, inadequate base rates, may not achieve the desired outcome of sustainability for the long-term system. It is imperative that adequate funds be invested to meet the growing need for home and community based services and to increase base rates for underpaid service sectors. The Task Force strongly supports the intent of Act 56, which requires that “Any savings realized due to the implementation of the long-term care Medicaid 1115 waiver shall be retained by the department and reinvested into providing home- and community based services under the waiver.”</p>
	<p>3 a. DAIL should develop a method for equitably allocating resources to serve both elders and adults with disabilities, based on the relative number of people to be served in each population.</p>
	<p>4 a. The relative acuity of persons receiving LTC services should be considered in efforts to achieve equitable reimbursements across components of the LTC system, so that the complexity of care delivered is reflected in the reimbursement rate.</p>

<p>5. Continue to find ways to right-size the nursing facility industry with the goal of maintaining (1) an adequate number of resident beds to meet the need the next 10 years and (2) nursing facilities as a quality LTC option. Efforts will include:</p> <ul style="list-style-type: none"> <li>• Supporting quality improvement and culture change initiatives as described in the report from the Nursing Facilities for the 21st Century Task Force.</li> <li>• Helping interested nursing facilities to right-size their facilities, including pursuing the concept of contracting for Medicaid resident bed days as one potential method.</li> </ul>	
<p>6. Strengthen, support, and invest in the development of housing with supportive services, through the construction of additional housing units and by bringing supportive services to current housing sites and naturally occurring retirement communities. Work with the public, non-profit and private housing industries and other appropriate parties to design a 10-year plan that will achieve this objective.</p>	
<p>7. Continue the efforts to ensure an adequate supply of well-trained and supported direct care workers by promoting culture change, supporting training, the development of a state-wide caregiver registry and publicly recognizing the importance and value of this career choice. The Direct Care Workforce Task Force will provide recommendations for accomplishing these goals in its final report in December 2007. (See page 49 for their interim recommendation.)</p>	

<p>8. Strengthen access to quality mental health services for elders and adults with disabilities by:</p> <ul style="list-style-type: none"> <li>• Increasing funding for the Eldercare Clinician Program.</li> <li>• Creating the expertise in DAIL, in collaboration with the Department of Health, Division of Mental Health, to offer support to nursing facilities and community based providers to appropriately address the mental health issues of the people they serve.</li> </ul>	<p>8 a. Systems development and ongoing support of quality mental health services must be adequately funded in order to address widespread gaps in these services for elders and adults with disabilities.</p>
<p>9. Continue to strengthen consumers' access to complete and unbiased information about LTC services by seeking on-going funding to support the development and ongoing operation of Aging and Disability Resource Collaboratives (ADRCs).</p>	<p>9 a. Information/Referral/Assistance (I/R/A) systems and system development for elders and adults with disabilities must be adequately funded. ADRCs are one model for providing I/R/A, but until the effectiveness of the Vermont pilot projects are evaluated, it is premature to allocate state funds to support their development and ongoing operation.</p>
<p>11. Research the costs, benefits, and risks to the state and to consumers of various methods that have the potential for bringing non-Medicaid revenues to meet Vermonters' long-term care needs, such as reverse mortgages and long-term care insurance.</p>	
<p>12. An extended study of the sustainability of the LTC system is needed. The work started by this Task Force should continue, with adequate time, funding, and expert technical assistance provided to accomplish its work. An extended study should include research on financial incentives and financing mechanisms that can assist the development of infrastructure to support home and community based services.</p>	

## RECOMMENDATIONS FROM THE NURSING FACILITIES FOR 21<sup>ST</sup> CENTURY STUDY

The Nursing Facilities for the 21<sup>st</sup> Century Task Force made separate recommendations to DAIL, nursing facilities, and the Legislature. These recommendations were also adopted by the LTC System Sustainability Task Force.

The Nursing Facilities for the 21<sup>st</sup> Century Task Force recommends that **DAIL**:

1. Support the infrastructure of the Gold Star Council and encourage nursing home facilities to participate in the Gold Star process.
2. Continue the Nursing Facility Quality Awards as a way to promote quality and best practices.
3. Use Civil Money Penalties<sup>45</sup> to promote culture change and celebrate diversity in ways that enhance the quality of life and/or quality of care for residents.
4. Strengthen the Long-Term Care Ombudsman program as a way to assist with culture change in facilities.
5. Determine whether or not the way allowable costs are allocated for space rented or used for community purposes is a financial barrier to facilities providing those spaces.
6. Continue discussions with facilities about the best method for right-sizing the industry, including the model of contracting for resident days. Any plan agreed upon should also recognize the importance of quality care in the contracting process.
7. Examine incentives to accomplish right-sizing of the industry such as bed-banking and conversion of multi-bed rooms to rooms with double and single occupancy.<sup>46</sup>
8. Research financial incentives and financing mechanisms that can assist existing nursing facilities to develop home-like settings.
9. Analyze whether the threshold of \$750,000 for renovation projects is an appropriate level to trigger the filing of a Letter of Intent re: the determination of whether or not a CON is required.
10. Develop criteria to help decide when major renovation projects should be approved.
11. Analyze the need for additional palliative care services as a specialty in nursing facilities.
12. Work with facilities to determine what is needed to properly care for geriatric patients at the State Hospital and those being furloughed from the Correctional system who would be better served in a nursing facility.
13. Clarify information about assistive technology, i.e. what is covered, by whom, and the most effective ways of obtaining the needed items. Provide this information to facilities, residents and families.

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<sup>45</sup> Civil Money Penalties are funds collected from nursing facilities that have been out of compliance with Federal requirements.

<sup>46</sup> The State of Vermont *Licensing and Operating Rules for Nursing Homes, December 15, 2001*, Section 8.4 (e) (3) and (4) require that “Any downsizing or reduction in licensed capacity initiated by the facility must first reduce the number of beds contained in three- and four-bed rooms such that these rooms are converted to semi-private or private occupancy.” The Rules also require that “Proposals for new construction, expansion, renovation or substantial rehabilitation of a facility requiring Certificate of Need approval pursuant to 18 V.S.A. §9434 will not be approved by the licensing agency unless the construction proposal includes a plan for elimination or conversion of all three- and four-bed rooms to rooms which accommodate no more than two persons.”

14. Identify barriers in the reimbursement system to the effective use of assistive technology and recommend changes at the state and federal level.

The Nursing Facilities for the 21<sup>st</sup> Century Task Force recommends that **nursing facilities:**

1. Find and/or develop reasons for community members to come to the facility on a regular basis as way to integrate the life of the residents into the life of the surrounding communities.
2. Adopt the Gold Star Employer Best Practices, with the additions recommended by the Task Force.
3. Determine ways to provide staff training and resident education that result in respect for both staff and residents who have various social backgrounds, sexual orientation, religious affiliations and from various races.
4. Participate in town and regional planning initiatives.
5. Seek additional ways to include residents in decision-making about day-to-day life in the facility.
6. Improve the dining experience for residents and visitors, e.g. family-style dining to encourage socialization; cultural sensitivity, and resident-determined dining schedules.
7. Make the facility more accessible for both residents and visitors; pay particular attention to resident rooms when planning renovations.
8. Prepare and serve food as close to the residents' living area as possible.
9. Pay particular attention to learning and responding to residents' requests to sleep, dress, bathe and engage in other activities on their own schedules.
10. Use new information technologies to better utilize staff time and improve resident care and quality of life, e.g. for scheduling, MDS assessments, tracking provision of care.
11. Educate residents and family members about the availability of assistive technology and facilitate obtaining any needed items.

The Nursing Facilities for the 21<sup>st</sup> Century Task Force recommends that the **Legislature:**

1. Set aside funding to develop a 10-year plan which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the residents' preferences, customs and individual histories. We have seen that the nursing facilities support these changes and are striving to implement many of them; however, there are many regulatory and reimbursement issues to be explored in depth before long-range plans that would achieve significant changes can be put in place.

## RECOMMENDATIONS FROM THE NURSING FACILITY REIMBURSEMENT STUDY

1. Retain current occupancy adjustments – The current occupancy adjustment methodology should be made permanent before it expires at the end of SFY 2007 and the State is forced to re-institute the previous methodology. The State also should develop a process for re-calculation of facility occupancy rates between rebase periods when beds are taken off-line.
2. Institute more frequent rebasing of Nursing costs – Nursing costs should be rebased biennially. Rebased costs should be updated to the year they are put into effect using the inflator described below in recommendation three.
3. Enhance Nursing Care Inflator in non-rebase years – At a minimum, the Nursing Home Market Basket (NHMB) inflation index for Nursing Care should be increased each year by one percentage point, to better reflect the facilities' year over year experience.
4. Reduce lag between rebase and effective years – Rebased costs should be incorporated into Nursing Facility rates more rapidly than occurs under the present system.
5. Reclassify Minimum Data Set (MDS) Coordinator costs – MDS Coordinator costs should be moved from the Indirect to the Nursing cost center, as these individuals usually are nurses.
6. Reclassify Geriatric Aide costs – Salary and benefit costs for geriatric aides should be moved from the Indirect to the Nursing cost center, after development of uniform job descriptions and evaluation of the cost implications of this move.
7. Evaluate and develop appropriate dementia/behavioral health payment rules – In calendar year 2007, the rules related to enhanced reimbursement for dementia/behavioral health cases (case mix category 45) should be re-evaluated and revised as appropriate. The current rules require eight consecutive hours of one-on-one care, but this requirement may not always be consistent with best practices.
8. Evaluate and develop appropriate methods for responding to unanticipated increased costs – In calendar year 2007, the State should evaluate the potential impact of unanticipated and systemic increases in costs – such as health insurance, liability insurance, worker's compensation and fuel costs – and respond as appropriate within the reimbursement system.
9. Study case mix system – Although beyond the scope of this project, the Task Force recommends that the State conduct a broader study of the existing case mix system as it relates to payment for persons with dementia to ensure the current RUGS classifications and payment differentials are appropriate and reimbursement is tied to best practices for this condition.

## **RECOMMENDATION FROM THE DIRECT CARE WORKFORCE STUDY – INTERIM REPORT**

The Direct Care Workforce study is not scheduled for completion until December 2007; however, an interim report will be delivered to the Legislature in January 2007. The Statewide Advisory Group has spent several meetings defining the scope of the study, including each type of direct care worker and provider to be included, the research questions that must be answered and the best strategies for gathering information from key informants. The Statewide Advisory Group recommends that a complete, thorough and therefore expanded study of the Direct Care Workforce be undertaken, with additional funding to achieve this goal.

## **Appendices**

- A.** Glossary
- B.** H.881, Sec. 149 -- Nursing Facilities and the Home and Community Based System
- C.** HCBS (Home and Community Based Services) Options for 2015 forecasting spreadsheet
- D.** Projected Nursing Facility Bed Capacity 2005 to 2015 forecasting spreadsheet
- E.** Indexing spreadsheet with 4% projections
- F.** Ownership of Nursing Facilities
- G.** Resources
- H.** Long-Term Care Sustainability Task Force members

## Glossary

AAA	Area Agency on Aging
ACCS	Assistive Community Care Services (Medicaid)
ADRC	Aging and Disability Resource Collaboratives
ALR	Assisted Living Residence
ASP	Attendant Services Program
CMS	Centers for Medicare and Medicaid Services
COVE	Community of Vermont Elders
DAIL	VT Dept. of Disabilities, Aging, and Independent Living
DHRS	Day Health Rehabilitation Services (Medicaid)
ERC	Enhanced Residential Care
HASS	Housing and Supportive Services
HCBS	Home and Community Based Services
I/R/A	Information, Referral and Assistance
LTC	Long-Term Care
MDS	Minimum Data Set (nursing facility resident assessment)
PACE	Program for All-Inclusive Care for the Elderly
RCH	Residential Care Home
TBI	Traumatic Brain Injury
VAHHA	Vermont Assembly of Home Health Agencies
VCIL	Vermont Center for Independent Living
VHCA	Vermont Health Care Association

## Definition of Terms

adult with a disability	persons age 18 and over with a disability
Choices for Care	Demonstration Medicaid waiver providing equal entitlement to home and community based services as well as nursing facility LTC.
elder/senior	Individuals age 60 or over. Entitled to services under the federal Older Americans Act
extraordinary financial relief	AHS/Division of Rate Setting rule Section 10 – Process by which nursing homes that are in immediate danger of failure may seek changes in their rates to stabilize their financial situation.
“going concern qualification”	A term used to describe a nursing facility’s financial situation. This qualification alerts all users of the financial statement that a nursing facility may not be able to continue in its accustomed business in the future.

Highest Need group	LTC Medicaid eligible individuals who are entitled to services under the Choices for Care waiver. If eligible, may <b>not</b> be placed on a waiting list. Have the highest clinical need.
High Need group	LTC Medicaid eligible individuals who are entitled to services under the Choices for Care waiver. If eligible, <b>may</b> be placed on a waiting list if funding for services is not available.
indexing	Indexing is defined as a method of calculating an appropriate annual increase. Most national indexes, e.g. Consumer Price Indices or Health Care Index are constructed using many separate expenditure categories that are then assembled in a “market basket” index.
MDS	Minimum Data Set – the assessment used in nursing facilities to determine the care needs of the resident.
Moderate Need group	Demonstration group under the Choices for Care waiver. Designed to test the efficacy of providing preventive services before nursing facility level of care is needed. No entitlement to services.
nursing facility certification and licensure	<u>Certification</u> is the federal process run by the Centers for Medicare and Medicaid Services (CMS) which sets the requirements for nursing facilities and then certifies that facilities meet those requirements. Facilities cannot bill for Medicare and Medicaid reimbursement without those certifications. <u>Licensure</u> is the state process that ensures facilities follow the state regulations.
optimal occupancy	Nursing facilities report that optimal occupancy for most is about 96 percent to 97 percent.
Medicare and Medicaid “beds”	Nearly all resident beds in Vermont are dually certified as both Medicaid and Medicare beds, i.e. the payment source does not dictate to which part of the facility the resident is assigned.

**Excerpt from H. 881, Sec. 149 - Nursing facilities and the Home and Community Based System**

Sec. 149a. Sec. 1a of No. 56 of the Acts of 2005 is amended to read:

Sec. 1a. TASK FORCE ON THE FUTURE SUSTAINABILITY OF NURSING HOMES as amended by the Senate and passed by both Houses.

(a) It is the intent of the general assembly that the department of disabilities, aging, and independent living collaborate with nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers to develop a long-range plan to address the sustainability of Vermont's long-term care system.

(b) The commissioner of disabilities, aging, and independent living shall convene a task force to assist the commissioner in developing statewide recommendations on the future of nursing homes, including the Vermont Veterans' Home, in Vermont. The recommendations shall address the transition issues for nursing homes as more individuals use home- and community-based long-term care services, how nursing homes can convert the services offered to provide long-term care services differently, unmet needs for nursing home services for individuals, accessibility for individuals with disabilities in nursing homes, an annual projection of the number of nursing home beds to meet the projected need over the next 10 years reported by region, the development of adequate home- and community-based services to support increased numbers of Vermonters receiving that type of care, whether indexing is an appropriate method of sustainable funding for home- and community-based services, and the methods which nursing homes can use to become more resident-centered in the provision of long-term care. The task force shall include representatives from providers of long-term care and organizations representing individuals receiving long-term care. The department of disabilities, aging, and independent living shall chair the task force and shall provide administrative support. One member of the house, to be appointed by the speaker of the house, and one member of the senate, to be appointed by the committee on committees, shall be included in this task force and are authorized to attend up to four meetings outside the legislative session. Legislative members of the task force shall be entitled to compensation and reimbursement for expenses under section 406 of Title 2.

(c) The commissioner of disabilities, aging, and independent living shall convene a second task force to analyze Medicaid reimbursement rates for nursing homes. The task force shall include three representatives of the Vermont health care association, one each representing for-profit, not-for-profit, and independently owned facilities; the director of the office of Vermont health access or designee; and the director of the division of rate setting in the agency of human services. This task force shall coordinate as necessary with the task force developed under subsection (b) of this section. This task force shall make recommendations on changes to the rules, methods, standards, and principles for establishing Medicaid payment rates for long-term care facilities in order to meet the protocols and objectives of the Choices for Care Medicaid Waiver Section 1115. Of the appropriation in Sec. 149 of this act, a total of \$25,000 in funding is provided for this purpose. These funds shall be matched by the Vermont health care association.

# HCBS Options for 2015

Vermont 2015 Proj Use Rate = Vermont's 2015 projected use (number of clients) divided by the 2015 projected number of non-institutionalized 18+ disabled^.

2015 # to Serve is either the VT 2015 Proj Use Rate (State Average) multiplied by a county's number of 2015 projected non-institutionalized 18+ disabled **or** the 2015 Projected Use counts from Shaping the Future, Table 5, *whichever is higher*. (In order to achieve the vision of a more balanced long term care system, counties would need to perform at either the 2015 State Average Use Rate or their 2015 expected use in Table 5.) The asterisk denotes counties where the 2015 State Average Use Rate has been applied.

<b>Personal Care (CFC): Vermont 2015 Proj Use Rate:</b>		<b>25.0%</b>
# of 2015 Proj Personal Care clients	1,497	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

Personal Care (CFC)	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	22%	31%	13%	26%	23%	21%	33%	33%	24%	24%	18%	19%	18%	16%	24%
Actual # Served in 2005	970	76	40	60	207	11	95	16	38	52	41	96	72	59	112
2015 # to Serve	1,638	118	105	90	320	17	151	24	62	75	76	169	137	121	174
			*			*					*	*	*	*	
2015 Expected Use from Model:	1497	118	66	90	320	15	151	24	62	75	64	142	110	87	174

<b>Adult Day: Vermont 2015 Proj Use Rate:</b>		<b>21.5%</b>
# of 2015 Proj Adult Day clients	1,287	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

Adult Day	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	19%	76%	16%	42%	12%	16%	21%	24%	28%	15%	15%	8%	15%	16%	10%
Actual # Served in 2005	836	184	49	96	113	8	60	11	43	31	34	42	62	57	46
2015 # to Serve	1,593	257	91	146	273	14	95	20	75	59	65	145	118	104	132
			*		*	*				*	*	*	*	*	*
2015 Expected Use from Model:	1,287	257	80	146	183	11	95	20	75	46	53	61	97	89	74

<b>ERC: Vermont 2015 Proj Use Rate:</b>		<b>5.2%</b>
# of 2015 Proj ERC clients	311	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

ERC	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	4%	6%	1%	0.4%	4%		11%		0.6%	5%	4%	5%	5%	2%	5%
Actual # Served in 2005	182	15	3	1	34		30		1	10	10	26	22	9	21
2015 # to Serve	373	25	22	16	66	3	54	4	12	16	16	43	38	25	34
			*	*	*	*		*	*					*	
2015 Expected Use from Model:	311	25	6	1	60	0	54	0	2	16	16	43	38	16	34

<b>Attendant Services: Vermont 2015 Proj Use Rate:</b>		<b>6.4%</b>
# of 2015 Proj Attendant Svcs clients	381	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

Attendant Services Program	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	6%	4%	4%	5%	5%	2%	8%	15%	8%	6%	4%	12%	7%	7%	5%
Actual # Served in 2005	286	10	13	11	47	1	22	7	13	13	9	64	30	24	22
2015 # to Serve	447	21	27	20	81	4	30	10	19	18	19	87	42	31	39
		*	*	*	*	*				*	*				*
2015 Expected Use from Model:	381	13	17	14	62	1	30	10	19	16	11	87	42	31	28

<b>Homemaker: Vermont 2015 Proj Use Rate:</b>		<b>16.7%</b>
# of 2015 Proj Homemaker clients	998	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

Homemaker	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	15%	19%	15%	14%	5%	24%	7%	2%	23%	19%	29%	16%	27%	17%	12%
Actual # Served in 2005	648	47	45	32	42	12	20	1	35	41	64	81	111	61	56
2015 # to Serve	1,201	73	71	47	212	16	66	12	61	61	102	119	170	89	103

				*	*		*	*							*
2015 Expected Use from Model:	998	73	71	47	70	16	33	2	61	61	102	119	170	89	84

<b>ACCS: Vermont 2015 Proj Use Rate:</b>		<b>18.4%</b>
# of 2015 Proj ACCS clients	1,101	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

ACCS	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	16%	10%	11%	12%	9%	32%	27%	4%	16%	13%	25%	25%	31%	6%	14%
Actual # Served in 2005	713	24	34	28	82	16	76	2	25	28	56	128	127	22	65
2015 # to Serve	1,358	60	78	56	233	20	129	13	42	51	84	196	194	89	113

		*	*	*	*		*	*	*	*				*	*
2015 Expected Use from Model:	1,101	39	53	41	134	20	129	3	37	40	84	196	194	34	97

<b>Assisted Living: Vermont 2015 Proj Use Rate:</b>		<b>7.1%</b>
# of 2015 Proj Assisted Living clients	425	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

Assisted Living	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	6%	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	13%	0%	11%	25%
Actual # Served in 2005	250	0	0	0	26	0	0	0	0	0	0	65	0	42	117
2015 # to Serve	678	23	30	22	90	5	28	5	16	20	22	106	39	71	202

		*	*	*	*	*	*	*	*	*	*		*		*
2015 Expected Use from Model:	425	0	0	0	46	0	0	0	0	0	0	106	0	71	202

<b>Res Care Homes (Pvt): Vermont 2015 Proj Use Rate:</b>		<b>26.0%</b>
# of 2015 Proj RCH (Pvt Pay) clients	1,560	
# of 2015 Proj Non-instit 18+ Disabled	5,994	

Res Care Homes (Pvt Pay)	Vermont	Addison	Bennington	Caledonia	Chittend	Essex	Franklin	Grand Isl	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Actual Use Rate in 2005	23%	11%	62%	13%	32%	18%	12%	0%	37%	17%	17%	12%	38%	18%	3%
Actual # Served in 2005	1,000	26	188	31	288	9	34	0	58	36	37	60	154	64	15
2015 # to Serve	2,000	85	290	80	472	17	103	18	85	72	79	176	235	127	160

		*		*		*	*	*	*	*	*	*		*	*
2015 Expected Use from Model:	1,560	42	290	46	472	11	58	0	85	51	55	92	235	100	22

^ Disabled = Needing assistance with 2+ ADLs

**VERMONT DEPARTMENT OF DISABILITIES, AGING  
and INDEPENDENT LIVING  
NURSING FACILITY (NF) BEDS BY COUNTY  
RANKED BY BEDS PER 100 18+ DISABLED POPULATION**

**Projected Nursing Facility Bed Capacity 2005 to 2015**

County	Licensed NF Beds	Population 18+ Disabled	Licensed NF Beds per 100 18+ Disabled	Population 18+ Disabled	NF Bed Reduction Needed to	Licensed NF Beds at	NF Bed Reduction per Year for	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Residents @
	<b>Dec 2005*</b>	<b>2005 est.*</b>	<b>2005 est.*</b>	<b>2015 est.*</b>	<b>Reach '15 Target</b>	<b>2015 Target</b>	<b>2015 Target</b>	<b>Target</b>	<b>95% occup</b>									
Bennington	545	794	68.7	872	203	<b>342</b>	20	525	504	484	464	444	423	403	383	362	<b>342</b>	325
Washington	459	815	56.3	912	100	<b>359</b>	10	449	439	429	419	409	399	389	379	369	<b>359</b>	341
Orleans	262	469	55.8	532	56	<b>206</b>	6	256	251	245	240	234	229	223	218	212	<b>206</b>	196
Lamoille	130	278	46.7	346	5	<b>125</b>	0	130	129	129	128	128	127	127	126	126	<b>125</b>	119
Rutland	418	909	46.0	1023	6	<b>412</b>	1	417	417	416	416	415	414	414	413	413	<b>412</b>	392
Franklin	214	486	44.0	593	0	<b>214</b>	0	214	214	214	214	214	214	214	214	214	<b>214</b>	203
Caledonia	170	393	43.3	460	0	<b>170</b>	0	170	170	170	170	170	170	170	170	170	<b>170</b>	162
Windsor	322	760	42.4	885	0	<b>322</b>	0	322	322	322	322	322	322	322	322	322	<b>322</b>	306
Chittenden	581	1,433	40.6	1791	0	<b>581</b>	0	581	581	581	581	581	581	581	581	581	<b>581</b>	552
Windham	213	569	37.5	670	0	<b>213</b>	0	213	213	213	213	213	213	213	213	213	<b>213</b>	202
Addison	105	340	30.9	421	0	<b>105</b>	0	105	105	105	105	105	105	105	105	105	<b>105</b>	100
Orange	20	231	8.7	307	0	<b>20</b>	0	20	20	20	20	20	20	20	20	20	<b>20</b>	19
Essex	0	51	0.0	66	0	<b>0</b>	0	0	0	0	0	0	0	0	0	0	<b>0</b>	0
Grand Isle	0	46	0.0	71	0	<b>0</b>	0	0	0	0	0	0	0	0	0	0	<b>0</b>	0
<b>State Total</b>	<b>3,439</b>	<b>7,573</b>	<b>45.4</b>	<b>8,950</b>	<b>369</b>	<b>3,070</b>	<b>37</b>	<b>3,402</b>	<b>3,365</b>	<b>3,328</b>	<b>3,292</b>	<b>3,255</b>	<b>3,218</b>	<b>3,181</b>	<b>3,144</b>	<b>3,107</b>	<b>3,070</b>	<b>2,917</b>

**2015 Target: 45.4**  
Lic'd NF Beds/100 18+ Disabled

\* Data Notes: Includes Veterans Home and Wake Robin.  
Excludes Non-Medicaid/Non-Medicare Facilities (Arbors-12 beds, Mertens-14 beds).  
Disabled Population: Lewin Estimates 2005, defined as "needing assistance with 2 or more activities of daily living".  
NF Beds: DAIL Licensing and Protection, December 2005.  
Does not adjust for beds used by out-of-state residents.



## Ownership of Nursing Facilities

<b>Owned by “Chains”</b>	
Central Park Lodges (CPL) – Canadian-based corporation	Berlin Health & Rehab Center
	Burlington Health & Rehab Center
	Bennington Health & Rehab Center
	Redstone Villa
	Rowan Court Health & Rehab
	St. Johnsbury Health & Rehab Center
	Springfield Health & Rehab Center
Haven Health Care – New England chain	Haven Health Center – Rutland
	Haven Health Center – St. Albans
Genesis – Pennsylvania-based chain	Bel-Aire Center
	Morrisville Center
	Mountainview Center
Eden Park chain	Eden Park – Brattleboro
	Eden Park - Rutland
Kindred Healthcare – Kentucky-based chain	Starr Farm (50% ownership by Fletcher Allen Health Care)
	Birchwood Terrace Healthcare
<b>Vermont-Based Ownership Groups</b>	
Kingdom Care (Northeast Kingdom)	The Pines
	Maple Lane
	Union House
Tom Rice (owner)	Green Mountain Nursing Home
	Brookside Nursing Home
<b>Hospital-Based Nursing Facilities</b> (facilities that share a common wall with a hospital)	
Mt. Ascutney Hospital and Health Center	
Menig Extended Care (at Gifford Hospital)	

<b>Hospital-Related</b>	
(facilities under the hospital “umbrella”, but not physically connected to the hospital)	
Woodridge Nursing Home	
Centers for Living and Rehabilitation	
Helen Porter Healthcare and Rehab Center	
Derby Green Nursing Home	
<b>Not-for-profit Facilities</b>	
Greensboro Nursing Home	
Mayo Healthcare	
Elmore House	
Gill Odd Fellows Home	
Thompson House Nursing Home	
Vernon Green Nursing Home	
<b>For-Profit Independent Facilities</b>	
McGirr Nursing Home	
Franklin County Rehab Center	
Cedar Hill Health Care Center	
Newport Healthcare Center	
Prospect Nursing Home	
Crescent Manor Care Centers	
<b>State-owned Facility</b>	
Vermont Veterans Home	
<b>Non-Medicaid Facilities</b>	
Merten’s House	
Arbors Nursing Home	
Wake Robin-Linden Nursing Home (Medicare-certified)	

## Resources

The Long-Term Care Sustainability Task Force drew upon the following written resources in preparing this report.

*Nursing Facilities for the 21<sup>st</sup> Century*. DAIL, October 2006. [www.dail.state.vt.us](http://www.dail.state.vt.us)

*Nursing Facility Reimbursement Study*. DAIL, December 2006. [www.dail.state.vt.us](http://www.dail.state.vt.us)

*Prevalence, Hours and Economic Value of Family Caregiving, Updated State-by-State Analysis of 2004 National Estimates* by Peter S. Arno, PhD. National Family Caregivers Association and Family Caregiver Alliance (2006).

[http://www.thefamilycaregiver.org/pdfs/State\\_Caregiving\\_Databystate2006.pdf](http://www.thefamilycaregiver.org/pdfs/State_Caregiving_Databystate2006.pdf)

*Reimbursement Practices and Issues in Vermont's Long Term-Care Programs*. Prepared by the Paraprofessional Healthcare Institute for the Community of Vermont Elders (COVE). November 2006. COVE can be reached at 229-4731.

*SFY06 Residential Home Care Survey*. DAIL/DLP Quarterly Variance Report on June 15, 2006.

*Shaping the Future of Long-term Care and Independent Living*. DAIL, May 2006.

<http://www.dail.state.vt.us>

*Vermont Olmstead Plan*. Vermont Olmstead Commission, January 3, 2006.

<http://humanservices.vermont.gov/publications/olmstead-commission/vermont-olmstead-commission-comprehensive-plan/view>

*Vermont State Plan on Aging for Federal Fiscal Years 2007 – 2010*. DAIL, 2006.

## Long-Term Care Sustainability Task Force Members

Member	Organization	LTC Interest
Sen. Claire Ayer	VT Senate	Legislature
John Barbour	Champlain Valley Agency on Aging	area agencies on aging
Nancy Bourne	VT Health Care Association	residential care homes, assisted living
John Campbell	VT Ethics Network	DAIL Advisory Board
Rev. Bill Cobb	COVE/Faith in Action	elders, faith-based organizations
Peter Cobb	VT Association of Home Health Agencies	non-profit home health agencies
Peter Coutu	Riverside Life Enrichment Center	adult day programs
Janet Cramer	DAIL Advisory Board, Council on Aging for Southeastern VT, mental health practitioner	Elders, mental health
Don Dickey	Joint Fiscal Office	Legislature
Cassandra Edson	Legislative Council	Legislature
Nancy Eldridge	Cathedral Square Corporation	housing providers, Assisted Living Residences
Jennifer Fitzgerald	DAIL Advisory Board	elders, adults with disabilities
Dolly Fleming	Community of Vermont Elders	elder policy issues
Rep. Bill Frank	VT House of Representatives	Legislature
Rep. Patsy French	VT House of Representatives	Legislature
Anita Gervais	DAIL Advisory Board	elders, senior housing
Harriet Goodwin	DAIL Advisory Board	elders, adults with disabilities
Ken Gordon	Northeast Kingdom Area Agency on Aging	area agencies on aging
Susan Gordon	VT Assoc. of Professional Care Providers	direct care workers
Neil Gruber	Helen Porter Nursing Home	nursing facilities
Brendan Hogan	Office of VT Health Access	State government
Nancy Lang	AARP-VT, Cathedral Square Corporation, DAIL Advisory Board	elders, housing providers
Joyce Lemire	Council on Aging for Southeastern VT, DAIL Advisory Board	elders
Deborah Lisi-Baker	VT Center for Independent Living, DAIL Advisory Board	persons with disabilities
Sarah Littlefeather	Attendant Services Program eligibility committee, DAIL Advisory Board	persons with disabilities
Jackie Majoros	State LTC Ombudsman-VT Legal Aid	consumer rights and protection
Dorothy Malone-Rising	DAIL Advisory Board, nurse practitioner	elders, adults with disabilities
Diane Novak	Southwest Vermont Council on Aging	area agencies on aging
Judy Peterson	Central VT Home Health & Hospice	home health agencies
Steve Pouliot	VT Assoc. for the Blind & Visually Impaired	persons w/visual impairments
Holly Reed	DAIL Advisory Board, RSVP	elders. adults with disabilities
Michael Richman	DAIL Advisory Board	elders, adults with disabilities
Bob Rosenfeld	AARP-VT	elders
Mary Shriver	VT Health Care Association	nursing facilities, residential care, assisted living
Beth Stern	Central VT Council on Aging	area agencies on aging
Alicia Weiss	VT Coalition for Disability Rights	persons with disabilities

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